THE K–12 PUBLIC SCHOOL EMPLOYEE HEALTH BENEFITS REPORT

DESIGN PROPOSAL

Washington State Health Care Authority

HCA 52-151 (12/2011) VOLUME 1

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PROJECT OVERVIEW

INTRODUCTION

Approximately $1B in public funds makes up the annual employer contribution from 295 local school districts and nine educational services districts for employee insurance benefits (Table 1). Each district combines the State funds received with local levy monies, federal funds and other revenue sources to provide insurance benefits either directly or through contracts with benefit plan carriers, including the Health Care Authority (HCA). The 304 districts listed in Appendix A form a statewide K-12 array of separate employees' health benefits programs - from Blaine to Vancouver and Cape Flattery to Asotin - serving more than 200,000 K-12 public school employees and their dependents (Table 2).

Table 1
Adjusted Employee-Level Data
Total Premiums, Employee Contributions,
and Employer Contributions by Benefit

Benefit Type	Premium [1]	Employee Contribution [1]	Employer Contribution [1]
Medical	$1,083.6	$236.7 [2]	$846.9
Dental	173.2	1.3	171.8
Vision	25.6	0.0	25.5
LTD/life	16.3	0.0	16.3
Total	$1,298.6	$238.1	$1.060.5

[1] Total dollars are in millions.

[2] The 21.8% average employee contribution for medical coverage reflects the base year mix of employees/dependents and full-time vs. part-time employees.

Table 2
Washington K-12 Employees
Estimate of Members and Enrollees by Medical Tier

Tier	Estimated Employees	Estimated Enrollment in Medical Plans		
		Employees	Dependents	Total
Employee Only	57,458	57,458	0	57,458
Employee + Spouse	11,308	11,308	11,308	22,616
Employee + Child(ren)	27,117	27,117	44,304	71,421
Family	13,089	13,089	38,233	51,322
No Coverage	20,789	0	na	na
Total	129,761	108,972	93,845	202,817

In June 2011, Governor Gregoire signed into law Chapter 50, 2011 Laws 1st Special Session PV. Section 213 of this law includes a directive for the Washington State Health Care Authority to develop a proposal for a consolidated health benefits purchasing system for K-12 employees to be implemented as soon as the 2013-14 school year. The stated legislative intent for a consolidated purchasing system is to improve administrative efficiency, transparency, and equity in the delivery of K-12 public school employees' health benefits, and to dedicate any prospective cost savings back to Washington's public schools. The proposal is to include the design of a consolidated purchasing system and an implementation strategy for ensuring a successful transition.

This report is the culmination of the contributions of a broad group of organizations and individuals. A variety of stakeholders, including elected officials and public education officials, K-12 public school employees and their representatives, state agencies and other members of the K-12 public school system came together to inform the Health Care Authority in the development of a viable proposal and to discuss major impacts of transitioning from the current K-12 health benefits environment.

Stakeholders also helped educate the Health Care Authority project team about the challenges that would be faced and the opportunities for improvement under a consolidated purchasing system. The increased knowledge and productive discussions allowed for the creation of a proposal that is responsive to the stated intent of the State Legislature. At the same time, the report recognizes that the resultant consolidated system design will vary from each of the health benefits purchasing systems that currently exist among 295 public school districts and nine educational service districts and each district will experience impacts differently .

Despite the diversity of interests and perspectives regarding the value and effectiveness of a consolidated approach to health benefits purchasing, project participants made a substantial commitment to share their knowledge and expertise to produce a report that enhances the ability of the Governor and Legislature to make well-informed decisions.

This proposal addresses five key design elements of a health benefits' purchasing system:

1. The **system governance structure** responsible for strategic planning, policy development, and coordinating the interrelationships between the State, public school districts, public school employees, benefit insurance carriers, and the benefits' delivery system.
2. The makeup o**f the population served** by the system.
3. The **scope and structure of the benefits' portfolio** available through the system.
4. The **financing and administrative structure** of the system.
5. The **cost sharing responsibilities** of the State, districts, and employees.

BACKGROUND

This report is the most recent product in a line of research and analyses, studies and reports, and legislative activities that have occurred over the course of several years in response to ongoing interest

and concern by elected public officials, public education officials, public school employees and their families, and state and local financial officials. The cost-effectiveness and equity of employee health benefits for K-12 public school employees and accountability for State funds contributed on behalf of taxpayers have been at the forefront of their concerns.

Three events in particular informed and influenced the content of this report and are summarized below.

1993-1995 CONSOLIDATION ATTEMPT

In 1993, the Legislature amended Chapter 492, Laws of 1993, Section 214, to transition the exclusive purchase of public school district employees' insurance benefits to the Health Care Authority effective October 1, 1995, except in the case where this would cause disruption to an existing insurance contract. In that case the transition was to occur at the time the existing contract expired. The amended law also modified the composition of the Public Employees' Benefits Board to include one representative of active public school district employees and one representative of retired or disabled public school employees.

In 1995, the Legislature again amended Chapter 492, to repeal many of the 1993 amendments, including the transition of public school district employees to mandatory participation status in Health Care Authority purchased health benefits. The 1993 modifications to the Public Employees' Benefits Board were further amended so that the board representative for active school employees was a non-voting member until 12,000 school district employee subscribers enrolled with the Health Care Authority for health care coverage.

As a result of the unsuccessful 1993 attempt to consolidate public school employees' health benefits within the Health Care Authority, multiple organizations and individuals have expressed serious concerns over the negative impacts previously experienced and skepticism about the potential success of another attempt. It was recognized that another attempt would require due diligence in minimizing the potential for a similar outcome and the associated disruptions to employee benefits programs as a result of the transition.

Of particular note is the expressed desire by nearly all stakeholders for the Governor and Legislature to demonstrate a high level of sensitivity to the need for ongoing collaborative participation as the design of a new benefit purchasing system proceeds. To avoid an unsuccessful transition, stakeholders stressed the need for proper sequencing and timing of the benefit purchasing system implementation to ensure the transition from the current array of public school district employees' benefits purchasing programs to a consolidated purchasing system is sustainable.

One other source of skepticism about consolidation lingering from the 1993-1995 experience is the anticipated impacts to health care provider choice and reductions to benefit plan value. Under the 1993 statutory provisions, the Health Care Authority was directed to move benefits purchasing to a highly managed care arrangement, with negative impacts on choice and plan value. In 1993 health care reform focused on a system of managed care with strong emphasis on limiting costs through gate-keeping access to high-cost services and provider types. Since then, approaches to reform have evolved in a

different direction focused on effective use and coordination of care across the array of services. The 1993 amendment required the public employees' benefits board to attempt to achieve enrollment of all employees and retirees in managed health care systems by July 1, 1994. That provision was repealed in 1995.

This report addresses these and other concerns through the governance structure and implementation strategy options presented.

2010 STATE AUDITOR'S OFFICE PERFORMANCE REVIEW

In 2010, the State Auditor's Office conducted a performance review of the public school employees' health benefits array under authority of Initiative 900. The State Auditor's Office contracted with the HayGroup® to conduct a study to inform the performance review findings and recommendations. The HayGroup® study was completed in January 2011 and the State Auditor's Office report became available to legislators during the 2011 legislative session.

The issues identified and opportunities for improvement presented in the State Auditor's Office review generated proposed legislation that was never passed by the Legislature. However, the resulting discussions among legislators, the Governor's Office, and stakeholders became the impetus for directing the Health Care Authority to develop this report to the State Legislature containing a proposal for a consolidated K-12 employees' health benefits system for further legislative consideration.

The 2011 State Auditor's Office performance review presented three key recommendations:

1. Streamline the benefits array to improve efficiency, transparency, and stability.
2. Standardize coverage levels for more affordable and equitable health care benefits.
3. Reduce costs by restructuring the health benefits array.

In developing its project approach for this report, the Health Care Authority coordinated with the State Auditor's Office and the HayGroup® to assure access to the data previously gathered and to build on the knowledge accumulated through their efforts. Based on this cooperative effort and consultations with the Governor's Office and legislative staff, the Health Care Authority developed a project scope focusing on fulfilling the primary directive to propose a new consolidated benefits' purchasing system. The scope does not include an additional performance review of the current K-12 employees' benefits purchasing array. In addition, the Health Care Authority limited its focus to those topics contained in the State Auditor's Office report that had a direct relationship to the Health Care Authority proposal.

CREATION OF THE OREGON EDUCATORS BENEFITS BOARD

The 2007 Oregon State Legislature created the Oregon Educators Benefits Board to consolidate Oregon's public school employees' benefits under the purchasing authority of the Board on a mandatory basis, with limited exceptions. Implementation of the program began October 1, 2008, under a three-year staged plan to allow for existing collective bargaining agreements to run their full terms. The staged implementation is complete and the program is maturing and gaining increasing stability as it

accumulates cost and benefits utilization data and implements system wide purchasing policies and protocols.

In addition to Oregon laws and administrative rules pertaining to the program, the Oregon Educators Benefits Board maintains an informative website with valuable background information and operational information. The Health Care Authority has been in continuous discussion with Oregon Educators Benefits Board representatives, consultants, and contracted health benefits carriers to learn from their experiences and to explore alternative approaches to the design, management, and delivery of employee health benefits. Valuable information gained through interactions with the Oregon Educators Benefits Board is incorporated in the Health Care Authority proposed design and implementation strategy, and key lessons learned and experiences are highlighted in a case study presented in the report.

SCOPE

To achieve the breadth of the directive in the limited time available to complete the report in order to meet the December 15, 2011 deadline for presentation to the Legislature, the Health Care Authority developed a proposed project scope to capture the essential aspects of the directive in relation to the design and analysis of a consolidated purchasing system and implementation strategy.

Staff of the Health Care Authority interviewed a set of individuals from the Legislature and executive agencies actively involved with the K-12 system and state health care policy to confirm that the project scope captured critical areas of interest. As a result of those discussions, the project scope was finalized and subsequently guided the project activities to completion.

The project scope includes the following:

A. The goal to present a proposal for state-administered consolidated purchasing of K-12 public school employee health benefits through a program that advances:

   1. **Equitable access** to quality and affordable health benefits for all employees and their dependents with particular emphasis on eliminating major differences in out-of-pocket premium expenses for employees who do and do not need coverage for dependents.
   2. **Transparency** of quality financial data to support effective budget management, benefits purchasing, and consumer and provider engagement and accountability within an employees' health benefits purchasing system.
   3. **Cost-effectiveness** through leveraged purchasing, administrative process simplification, and efficient utilization of resources to minimize duplication and re-work.
   4. **Shared responsibility** through State, school districts and employee participation in program governance.
   5. **System wide integration** to foster a uniform approach to benefits purchasing based on collaborative decision-making and consistent policy and administration across school districts.
   6. **Value-based purchasing strategy** consistent with emerging State health care purchasing policy.

B. The described details to be addressed, as delineated in the directive, are organized into five major categories:

   1. At an aggregate program level and major program-component level, **the feasibility of integrating K-12 employees with the existing health benefits pool for state employees**, and the impacts that would occur.
   2. A **governance structure** that will enable local school districts to retain responsibilities and activities that are appropriately the purview of the employing agency while transitioning appropriate aspects of health benefits purchasing administration to the benefits purchasing agency and benefits system governing board.
   3. At an aggregate level, and in some cases at a specific topic level, **projected impacts for employees, school districts, and the State** resulting from the transition to the proposed consolidated state-administered system. These include impacts on employee access to subsidized health benefits, total program cost, equity of benefits among employee groups and individual employees, and administrative simplification.
   4. An **implementation plan** in sufficient detail to identify the processes, required activities, timeline, and budget required for successful implementation of necessary management, operations, information systems, etc. for a state-administered program start-up as early as the 2013-14 school year.
   5. Analysis of **design component options** outlined in the directive and the recommended choice among the options.

C. A recognition that the Health Care Authority's responsibility is to strive for objectivity in developing a viable approach to consolidated purchasing from the perspective of sound benefits purchasing policy and quality health care delivery.

D. Recognition that the Health Care Authority's proposed consolidated purchasing system and implementation strategy will become the springboard for further legislative discussion in a forum involving a diverse set of stakeholders, and therefore care must be taken to assure the proposed design has the flexibility to maintain viability under a reasonable degree of modification.

E. Recognition that the scope of discussion is employees' health benefits and recommendations and impact assessments should remain within that scope while acknowledging that employee health benefits is an element of a larger human resources system and changes in this element has direct impact on other aspects of employer/employee arrangements.

METHODOLOGY

Early on, the Health Care Authority identified four components critical to successful development of this report:

1. Project Governance and Direction
2. Proposal and Implementation Strategy Content Development

3. Actuarial Financial Modeling, Analysis, and Cost Comparison
4. Project Transparency and Stakeholder Engagement

Because of the high level of interest and concern among a diverse group of stakeholders and the potential for major impact to more than 100,000 public school employees and their families, transparency and stakeholder engagement were emphasized as a critical element for successful completion of the project.

The short time in which to complete the project and the importance of the final product to inform future decisions necessitated that the Health Care Authority draw upon the internal resources of multiple state agencies, school districts, associations of school officials, associations of school employees, legislative staff, and associations and individuals representing, insurance consultants and brokers, health benefits carriers, as well as Health Care Authority contracted actuarial consultants, communications consultants, and benefits administration consultants.

PROJECT TEAMS

All of these entities were organized into project teams to fully address the goals and objectives established for the project and multiple areas of key importance related to the design of a complex health benefits system, including eligibility requirements, funding sources, benefit plan designs, risk pooling, and the structure and resource needs associated with a purchasing system of this size. The team memberships are provided in Appendix B.

The project teams consisted of:

1. **Inter-agency Authorization Executive Team:** Made up of State officials responsible for policy and funding for the K-12 system and state purchased health care; this team included Cabinet level agencies and certain legislators.
2. **Project Leadership and Support Team:** Within the Health Care Authority, this group provided executive leadership for the project and was responsible for the report's timely delivery to the State Legislature.
3. **Project Design Team:** Responsible for developing the design options and project boundaries to be included in the report, this team included Health Care Authority executives and subject matter experts responsible for public employee benefits, pharmacy benefits, health care policy, legal services, fiscal services, actuarial services, and information technology services. A workgroup with expanded participants from an array of Health Care Authority operations functions was formed within the design team to prepare the implementation strategy. The core Health Care Authority design team was also supported by representatives from the Office of Financial Management, Office of the Insurance Commissioner, and Attorney General's Office.
4. **Implementation Input Teams:** Consisted of representatives from school districts, school district brokers, the Washington School Information Processing Cooperative (WSIPC), and Health Care Authority staff of information technology, legal, finance and operations. The implementation structure and design was informed through a series of meetings to receive input

on the requirements of a consolidated system, the options available, and the recommended approach. The implementation plan is informed by the recommendations and an estimate of required time and resources to successfully implement a consolidated system.

5. **K-12 Project Advisory Team:** Consisted of education professionals, labor representatives, insurance carriers, school districts, insurance consultants and brokers, and other interested entities. The Advisory Team agreed to serve in a dual role to provide accurate descriptions of the current K-12 employee benefits array and to share their perspectives and expertise to advance the quality and feasibility of a consolidated purchasing system design. The Health Care Authority accepted the participation of Advisory Team members with the understanding that participation did not constitute an endorsement of consolidation or an endorsement of the resultant proposal put forward by the Health Care Authority.
6. **Key Legislators and Legislative Staff:** This group offered insight to the project team during organized meetings and individualized discussions.

PROJECT SCOPE CONFIRMATION

In order to assure the final product delivered to the Legislature would be consistent with the desired outcome envisioned in developing the Section 213 directive, Health Care Authority staff met individually with the majority of the members of the Inter-agency Authorization Executive Team to share the proposed project scope. During the discussion, each member was asked to share his or her perspective on the issues of major concern and the opportunities for improvement in school employee health benefits purchasing.

Two meetings were also held with legislative staff members who support the legislative members of the Inter-agency Authorization Executive Team, the House and Senate Ways and Means Committees, and the four legislative caucuses. These individuals provided additional insight into the major issues and improvement opportunities and the discussions that had occurred during the 2011 legislative session.

The information gained through these discussions and meetings was incorporated into the final project scope used to guide activities throughout the proposal development.

TEAM MEETINGS

The project's Design Team organized the work around the two primary products:

1. Design of a consolidated purchasing system.
2. An implementation strategy.

The two activities were closely coordinated through a series of Design Team meetings to assure the proposed health benefits purchasing system could be successfully implemented and administered on an ongoing basis in close collaboration with the participating districts.

The Advisory Team membership grew as interested persons became aware of the project activities and eventually had approximately 30 regular participants. The team met on five occasions. All meetings were

held at the Puget Sound Educational Service District conference center with statewide video and audio connections available to members of the Advisory Team and other interested persons who could not attend in person. Participation was robust throughout the conception, modeling, and drafting stages of the project.

Members of the Design Team attended the Advisory Team meetings to share information and to experience the dialogue among the Advisory Team members. Each of the Advisory Team meetings was followed with a Design Team meeting to incorporate input received into policy and tactical features of the consolidated purchasing system proposal.

CHALLENGES AND LIMITATIONS

The project was undertaken in a challenging environment, which influenced the report content. The Health Care Authority took care to balance the need for presenting sufficient detail to adequately describe the structure of the proposed consolidated purchasing system and implementation strategy with the need to complete the report on time with meaningful information to inform the next phase of activity by the Legislature. The final degree of balance achieved is in large part due to the significant contributions of the project teams, as well as the individual school districts that devoted time and effort to the project over the course of five months.

Following are some key challenges and limitations that impacted the comprehensiveness and detail of the report content.

ALLOTTED TIME

In order for the dialogue generated by the State Auditor's Office review during the 2011 legislative session to maintain impetus into the 2012 session, the Health Care Authority was directed to complete its project by December 15, 2011, a period of approximately five and one-half months. Although the core elements of the project were addressed during the available time period, there remain areas where additional research, analysis, and design detail can enhance the quality of a consolidated health benefits purchasing system as it progresses to its finished structure.

IMPLEMENTATION TIMING – PENDING NATIONAL HEALTH REFORM

The Health Care Authority recognizes the legislative directive for implementation of the proposed program for the 2013-2014 school year, that is, as early as October, 2013. The Health Care Authority also recognizes the significant change management that would be required of the 300 plus affected school districts. In order to implement most effectively, for purposes of this report, Health Care Authority has assumed a January 1, 2014 implementation date. Should the Legislature concur with this recommendation its launch will coincide with implementation of major milestones for national health reform implementation on January 1, 2014. The timing of the two events creates a degree of uncertainty for the consolidated purchasing system's final design, given that many important elements of national

health reform will still be under development and outcomes of pending court reviews and impacts of the national election will occur during the implementation period.

Therefore, it is recommended that, upon legislative authorization to proceed with implementation of a consolidated health benefits purchasing system for K-12 employees, further analysis and recommendations be prepared regarding any leverage opportunities or boundaries that may exist with implementation of the Affordable Care Act.

DIVERSITY AND COMPLEXITY OF CURRENT K-12 EMPLOYEES' HEALTH BENEFITS

It is noted in the prior discussion of project scope that the consolidated health benefits purchasing system described in this report is based on aggregated data representative of the 295 individual school districts and nine educational service districts in Washington. The diversity and complexity of the individual employee health benefits programs currently operating across the state is such that any single district's benefits program will not match the consolidated purchasing system design and the positive and negative impacts of transitioning to the consolidated system will vary by district. The broad scope of the project and the limited time available prevented an impact analysis for each individual district.

EMPLOYEE BENEFITS SYSTEM PURCHASING AND ADMINISTRATION DATA AVAILABILITY

A comprehensive database covering the employee population eligible for and participating in any employee health benefits program is essential to the program purchaser and administrator making informed decisions to assure the program is designed and operated cost-effectively and provides high quality benefits. This includes data from school districts as the employer and contracted insurance benefit sponsors and carriers as the source of benefit services. For purposes of this report and all data discussions within the report, references to data and data transparency are solely oriented to data that is relevant to employee benefits purchasing and administration. This report does not extend into issues of data transparency unrelated to employee benefits program purchasing and administration, such as other aspects of school district operations, other aspects of State funding to districts, etc.

The greatest challenge for the project was data availability. Despite positive support from the majority of entities that are critical sources of K-12 employee demographic, payroll, and benefits data, at the end, the Health Care Authority was unable to collect a database encompassing the complete K-12 employee population and associated health benefits programs. This was due in part to the limited time available to gather this large volume of data and to resource and time conflicts created by the coinciding start of the 2011-12 school year. Additional details about the data collection process are provided in the report.

The following were some key factors impeding our ability to collect a complete set of data:

1. **Authority to Collect Data.** Because the directive did not speak directly to the Health Care Authority's authorization to collect data, districts and carriers were uncertain about their obligation to provide requested data. The nature and scope of data that could be requested by the Health Care Authority was also unclear.

2. **Protection of Sensitive Data.** Despite assurance by the Health Care Authority and the Attorney General's Office of adequate privacy and confidentiality safeguards:
    a. Districts and carriers expressed almost universal resistance to releasing data considered to be sensitive information identifiable at the individual employee level, and which could potentially become public, particularly in terms of medical claims data.
    b. Carriers expressed substantial resistance to releasing information felt to be proprietary in nature.
3. **Data Formats.**
    a. Although common databases are in use across the current K-12 public school system, the way data is formatted, the range of data reported, and the ease and flexibility to extract data from the databases varies significantly.
    b. Districts manage their databases through a variety of combinations of in-house staff, Washington School Information Processing Cooperative (WSIPC) services, and services of insurance consultants and third party administrators. Extraction of a broad range of data elements can be cumbersome and require long periods of time.
    c. Several school districts reported it required substantial hours of work and up to six weeks to complete the process of gathering and submitting their data. Once it was received, it took additional work to convert it into a consistent format that could then be analyzed by the Health Care Authority. In the end, a portion of the data could not be used.
4. **Data Transparency.** The degree to which the school districts have full access to data related to their health benefits costs and employee benefits utilization varies across school districts as a result of several factors, including:
    a. Variations in internal budgeting practices that impact the ability to isolate costs associated with health benefits administration.
    b. Contractual arrangements that transfer administrative duties to external parties thereby making it more complicated to accurately calculate total costs of health benefits administration.
    c. Contractual arrangements with benefits carriers which allow the carriers to withhold information about the make-up of premiums, including components of administrative fees, and claims information at the school district, employee bargaining group, or individual member level.
    d. Differing contractual arrangements between school districts, brokers, and carriers involving fees and commissions that are not always fully transparent to the school district.

The difficulties experienced by the Health Care Authority in gathering a uniform set of data elements from all school districts and major carriers underscores the need for major improvements in transparency of K-12 school employees' health benefits data. The data elements the Health Care Authority endeavored to collect are essential for the effective purchasing and administration of employee health benefits, whether by individual school districts, independent benefits trusts, or a consolidated statewide

purchasing system. Barriers to full data access, ease of access, and accuracy and uniformity of data specifically related to employee benefits purchasing and administration, including administrative and benefits utilization information at the individual employee level, are problems that need to be overcome regardless of the structure of the benefits system in place.

CONTINUING WORK

The Health Care Authority will continue to collect requested data from districts and carriers that were unable to fulfill the data request during the report development period and complete further analyses to inform discussions that may occur during the 2012 session.

CONSOLIDATED PURCHASING SYSTEM SCENARIOS

SCENARIO: CONSOLIDATED PURCHASING SYSTEM UTILIZING THE EXISTING PUBLIC EMPLOYEES' BENEFITS BOARD PROGRAM (PEBB PROGRAM)

OVERVIEW

The board of directors of the state's school districts and educational service districts are authorized to obtain insurance benefits on a voluntary basis for their employees and their dependents through a contractual arrangement with the Health Care Authority. The Health Care Authority in turn provides enrolled members access to the program for the benefits specified in the negotiated contract with the individual district. Fifty school districts and four educational service districts have contracts in place in 2011 to receive Public Employees' Benefits Board program services for one or more employee groups of the district. There are approximately 4,700 enrolled members from predominantly small districts with enrolled members by individual district ranging from two to 350.

One potential strategy considered for consolidated K-12 employees' health benefits purchasing involved restricting the K-12 boards of directors to a single source of employee insurance benefits through the existing Public Employees' Benefits program. This would incorporate all public school employees into the single community-rated risk pool established in 41.05.022 RCW and subjecting them to the applicable provisions and requirements of state law related to the financing and administration of the PEBB program.

An adapted version of this potential strategy was also considered. This version involved consideration of the feasibility of removing the prime negative impacts imposed by current regulatory and administrative requirements of the PEBB program, as identified in the initial analysis.

ASSUMPTIONS

For purposes of analyzing this potential strategy, the following assumptions were initially used:

1. School employees continue to be treated as employees of the individual school districts and educational service districts, not as employees of the state.
2. The composition and duties of the Public Employees' Benefits Board are unchanged.
3. The Public Employees' Benefits Board program covered benefit offerings and combination of self-insured and fully-insured benefit plans are unchanged.

4. The Public Employees' Benefits Board program contracted insurance carriers and third party administrators are unchanged.
5. The school system's annual insurance benefits cycle is October 1 through September 30.
6. State contributions for school employee benefits continue to be determined in the same manner currently utilized by the Office of Financial Management and the Legislature.

Assumptions 2, 3, 4, and 5 were suspended to support the analysis of the adapted strategy.

INITIAL ANALYSIS

This analysis is structured in a manner that is consistent with the stated goals of the project and the features of an insurance benefits purchasing system used throughout the report. The goals and features addressed in the analysis are:

A. Design Features:
    1. Decision-making authority
    2. Governance structure
    3. Eligibility criteria
    4. Covered benefits and benefit portfolio design
    5. Benefit delivery system
    6. Purchasing system financing
    7. Purchasing system administration and operations
B. Goals:
    1. Equitable access to employee health benefits
    2. Transparency
    3. Cost-effectiveness
    4. Shared Responsibility
    5. System wide Integration
    6. Value-based purchasing

DECISION-MAKING AUTHORITY

No major impact occurs to the decision-making authority or responsibilities of the Health Care Authority as the purchasing system administrator.

Districts experience no major impacts to the decision-making authority in their role as the employing agency and the respective responsibilities associated with:

1. Establishing the scope of insurance benefits offered to their employees.

2. Establishing the terms of coverage.
3. Establishing budgets to cover the costs of insurance benefits.
4. Establishing the employer contribution to the premium.

The districts do experience a substantive restriction in their authority to select the method of providing *basic benefits*; transitioning from the authority to directly provide benefits or contract with carriers of choice to required use of the Health Care Authority to obtain the *basic benefits*.

One major impact borne by the employee representatives that bargain on behalf of employees is the lost ability to negotiate the benefit design of the PEBB program portfolio, and in particular the employee's point of service cost sharing contributions. A more limited impact is the reduced array of benefit plan options from which to negotiate the plans offered to their represented bargaining unit.

In the event the Health Care Authority expands the PEBB program to include other types of insurance considered to be *optional benefits* in the K-12 system, the identified impacts potentially will be similar for those offerings.

GOVERNANCE STRUCTURE

Section 41.05.055 RCW specifies the Public Employees' Benefits Board composition as:

1. Two representatives of state employees one of whom shall represent an employee union certified as exclusive representative of at least one bargaining unit of classified employees, and one of whom is retired, is covered by a program under the jurisdiction of the board, and represents an organized group of retired public employees.
2. Two representatives of school district employees, one of whom shall represent an association of school employees and one of whom is retired, and represents an organized group of retired school employees.
3. Four members with experience in health benefits management and cost containment; and
4. The Director of the Health Care Authority.

Subsection (3) of this section specifies that the member who represents an association of school employees and one of the four members appointed as a person with experience in health benefits management and cost containment shall be nonvoting members until such time that there are no fewer than twelve thousand school district employee subscribers enrolled with the Health Care Authority for health care coverage. This provision is currently in effect due to the limited participation by school districts.

The Public Employees' Benefits Board has no membership dedicated to represent district officials.

Including substantially more districts in the Public Employees' Benefits Board program will surpass the 12,000 subscriber threshold thereby increasing the voting members to the full complement of nine. The addition of substantially more districts will have no impact on the composition of the board membership and the absence of a voting member designated to represent local districts. As a result district

officials will suffer a restricted ability to influence board determinations of policy, benefit design, fiscal management and other aspects of employee insurance benefits management that directly impact their budgets, operations, and employees.

ELIGIBILITY CRITERIA

Chapter 41.05 RCW and associated administrative rules establish parameters for district participation in the PEBB program including the following citations relating to employee and dependent eligibility:

1. The authority, or at the authority's direction, an employing agency shall initially determine and periodically review whether an employee is eligible for benefits pursuant to the criteria established under this chapter. [41.05.009(1)]
2. An employing agency shall inform an employee in writing whether or not he or she is eligible for benefits when initially determined and upon any subsequent change, including notice of the employee's right to an appeal. [41.05.009(2)]
    - Each employer group determines employee and dependent eligibility for PEBB insurance coverage in accordance with the criteria outlined in its contract with HEALTH CARE AUTHORITY. [180-08-230 WAC]
3. Every employing agency shall carry out all actions required by the authority under this chapter including, but not limited to . . . appeals process. [41.05.008(1)]
4. Employing agencies shall report all data relating to employees eligibility to participate in benefits or plans administered by the authority in a format designed and communicated by the authority. [41.05.008 (2]
5. Employer groups obtaining benefits through contractual agreement with the authority for employees defined in RCW 41.05.011(6)(a) through (d) may contractually agree with the authority to benefits eligibility criteria which differ from that determined by the board. [41.05.065(4)]

As outlined, for current voluntary K-12 districts choosing to participate in the PEBB program, eligibility rules and employee contributions are established and maintained at the local district level. Mandatory program enrollment for K-12 would not change this practice. In addition, there would be no impact to the decision-making arrangements of districts and their employee bargaining units.

COVERED BENEFITS AND BENEFIT PORTFOLIO DESIGN

A substantial impact is experienced due to multiple changes that occur for employees related to both the covered benefits and the diversity of the benefit portfolio.

The PEBB program provides access to the five defined K-12 basic benefits defined in 28A.270 RCW but with differing relative values of the benefit plan design arrangements than currently exist across the spectrum of district employees' benefits programs. The primary driver of the differing relative values is employee point of service cost-sharing responsibilities in terms of deductibles, co-insurance/co-payment, and out-of-pocket maximum limits. The relative value range of benefit plans is substantively narrower in

the PEBB program with the current K-12 portfolio extending beyond the PEBB program at both the upper and lower ends of the range. This results in fewer benefit plan choices and a less diverse set of options in terms of affordability for differing income levels.

In addition to the variations in benefit plan design and premium cost-sharing arrangements, a substantive difference results from the Public Employees' Benefit Board program integrating the vision benefit into the medical benefit. The K-12 approach provides the district and its bargaining units the flexibility to choose not to offer the vision benefit while still offering the medical benefit. The PEBB program arrangement necessitates that the vision benefit be purchased in combination with the medical benefit. This also results in vision services being provided only through the carriers selected to provide medical benefits.

For the dental, life and long-term disability insurance benefits, the district and bargaining unit retain the flexibility to choose on a benefit by benefit basis whether to cover the *basic benefit* for employees of that bargaining unit.

Districts currently have the authority to offer other insurance benefits as *optional benefits*, such as medical gap insurance and short-term disability insurance. The PEBB program does not purchase other types of insurance on behalf of participating employing agencies and therefore does not have the ability to offer an optional benefit a district has agreed to cover as an employee benefit.

BENEFIT DELIVERY SYSTEM

Districts contract with a broader array of insurance carriers and third party administrators for the provision of fully-insured and self-insured medical benefits but the majority of members are enrolled in fully-insured medical plans sponsored by six entities: WEA-Premera, Group Health Cooperative, Regence Blue Shield, Premera Blue Cross, Kaiser Permanente, and Kitsap Physicians Service. More than half of participating employees subscribe to the WEA-Premera sponsored plans.

The PEBB program contracts with two fully-insured plan sponsors, Group Health Cooperative and Kaiser Permanente, and with Regence Blue Shield for third party administration for the Uniform Medical self-insured plan. Greater than 60% of participating employees subscribe to the self-insured Uniform Medical Plan.

Because the PEBB program does not contract for fully-insured medical plans sponsored by WEA-Premera, Regence Blue Shield, or Kitsap Physicians Service, an impact occurs for those employees who lose the affiliation with an entity as a plan carrier, and in particular the loss of affiliation with the WEA-Premera plans.

Because of the overlap with Group Health Cooperative and Kaiser Permanente, and the Premera Blue Cross and Regence Blue Shield affiliation with the national Blue Cross/Blue Shield Association, only minor impacts occur in terms of access to network providers. Previous provider network comparisons performed by the Health Care Authority indicate that major medical plan sponsors in Washington have contracted provider networks that include most inpatient facilities, major outpatient facilities, and

professional provider categories, with the exception of professions such as naturopaths, acupuncturists, and massage therapists.

The plan sponsors utilized by the K-12 system and the PEBB program for the most part overlap and no substantive impact to provider access occurs based on the information available at the time of analysis.

Of note is an issue related to the vision benefit delivery system raised in discussions with the project Advisory Team. Reportedly, some districts have chosen to contract for vision services separate from their contracted medical benefit plans and have experienced meaningful savings, particularly when contracting with a specific national provider for the majority of the district vision benefit business. The PEBB program purchases vision services as a component of the contracted medical plans and the Uniform Medical Plan and is not aware whether the named national vision benefit provider is utilized by the fully-insured medical plans. Several members of the Advisory Team highlighted the importance of the vision benefit to employees and the potential impact of losing access to the current level of benefit, and in some cases to the named national provider.

PURCHASING SYSTEM FINANCING

This analysis revealed the greatest impact occurs in relation to two financial aspects of K-12 employees' benefits purchasing described below.

A. **Requirements for payment to the PEBB program:** Each district currently receives an established state allocation for health benefits for the state funded FTE positions that the district uses in combination with other revenue sources (Federal, local, other) to establish its employee benefits budget. The district then establishes an employee insurance benefit allocation to each employee according to district policy and collective bargaining agreements. Based on district policy, the allocation is used to cover a defined benefit package which includes a medical plan selected by the employee. School districts have many employees who have benefit eligibility based on less than a full FTE, in which case a pro-rated FTE factor may be used.

   Section 41.05.050 RCW requires that the Health Care Authority collect from each participating school district and educational service district an amount equal to the composite rate charged to state agencies, plus an amount equal to the employee premiums by plan and family size as would be charged to state employees, for groups of district employees enrolled in authority plans, with limited exception. In accordance with 182-08-190 WAC, the district must pay premium contributions to the Health Care Authority for insurance coverage for ***all*** eligible employees and their dependents. The entire employer contribution is payable to the Health Care Authority for each eligible employee even if the employee waives medical coverage. This revenue is pooled at the program level and distributed across program costs.

   The impact of transitioning from the current insurance benefits funding arrangements to the mandated PEBB program funding arrangement is twofold. First, the historical experience demonstrates that the state allocation amount provided to districts and the composite rate

charged to districts for participation in the PEBB program do not consistently match (Appendix C). In 2011 the state allocation to districts is less than the charge assessed to districts participating in the PEBB program.

The requirement for the district to pay the full employer premium contribution for all eligible employees, including those that waive medical coverage, negates the ability of districts to retain unused public funds and redistribute them to reduce the premium costs of enrolled employees. This is further exacerbated by the fact that the PEBB program employee premium contributions are not prorated by FTE level; therefore the district is liable for an employer contribution to the PEBB program as if all participating employees are at the 1.0 FTE level of the district pro-rating formula.

The increased cost is substantial for districts and employees in those districts employing numerous part time employees when a sizeable number waive their medical benefit coverage. The Health Care Authority collects the full employer contribution for these individuals, regardless of district level prorating practices, and pools these funds at the PEBB program level. The existing bargaining unit level funding pools may continue, but the funding for the pools will be substantially diminished due to the loss of any funds that result from an employee waiving coverage.

B. **Funding established target reserve levels for the Uniform Medical Plan:** The Uniform Medical Plan constitutes more than 60% of current PEBB program enrollment. As the state's self-insured medical plan, the Heath Care Authority has established target reserve levels. Current reserve levels and population risk calculations are based on the existing enrollment numbers and member experience and do not account for an increased enrollment by a population of the size of the current K-12 system.

   Inclusion of all K-12 districts results in two large impacts:

   1. A substantial amount of additional up-front surplus funding by the Legislature for the Uniform Medical Plan would be required to reach the targeted reserve levels.
   2. Lack of available member claims experience data across the current K-12 population introduces a high level of uncertainty when projecting the cost of care that will be incurred by the Uniform Medical Plan for the first two to three years and puts the Uniform Medical Plan budget at an unknown level of risk.

PURCHASING SYSTEM ADMINISTRATION AND OPERATIONS

Initial analysis of data collected relating to the array of life and long-term disability offerings in the current K-12 system indicate important differences from the offering in the PEBB program. The nature and degree of the differences in benefit design suggest impacts to public school employees due to the loss of value in these benefits resulting from moving to the PEBB program benefit designs.

The information exchange infrastructure within the current system creates considerable challenges for implementation in the PEBB program. A system upgrade is required to make these covered benefits manageable throug the existing PEBB program infrastructure.

In addition to the described design and infrastructure impacts, a third potential impact is created by the timing offset between the school year that runs from October through September and the PEBB program benefit year that runs from January through December for the state agencies and the majority of employing agencies. At this time the PEBB program does make provisions for those school districts and educational service districts participating in the PEBB program. The impacts of adjusting the PEBB program to accommodate all school districts on a different cycle than other participating employers require further discussion and analysis.

ADAPTED STRATEGY

The Health Care Authority decided to conduct a second analysis of this purchasing strategy in which reasonable adaptations to the PEBB Program were assumed as follows:

1. The composition of the PEB Board is modified to include one member representing an association of school officials.
2. The PEB Program's medical benefits portfolio is expanded to be more comparable to the existing K-12 portfolio in terms of relative value. The upper end of the PEBB portfolio is comparable to the relative value of the WEA-Premera Plan 2 by increasing the relative value of the Uniform Medical Plan.
3. The expanded PEBB Program portfolio is procured though a competitive procurement process to assure adequate carrier capacity and minimize disruptions in K-12 employees' access to current network providers.

These assumed adaptations to the PEB Board composition and the PEBB portfolio do not alleviate several substantive impacts, such as increased premium contributions for the districts, the financial stability of the Uniform Medical Plan, costs for the Health Care Authority infrastructure upgrades, inequities in employees' access to health benefits, and implementing system-wide integration.

SUMMARY OF FINDINGS

This analysis identifies several areas of impact that demonstrate the problems associated with using the existing Public Employees' Benefit Board program as the sole source for school district and educational service district insurance benefits. This purchasing strategy requires blending of two different business models:

1. The state employees' benefits system business model that is tailored to: (a) the state functioning as the single employer for all state employees, (b) a single state employees' health benefits

purchasing system, and (c) a single super-coalition collective bargaining process conducted by the State Labor Relations Office to set the employer contribution to premiums.

2. The K-12 employees' benefits business model that is tailored to: (a) over 300 individual district employers, (b) over 300 employees' health benefits purchasing systems and (c) collective bargaining at the individual school district level involving multiple separate employee bargaining units.

From the perspective of the districts and employees, following the PEBB program's current practices minimizes impacts. Beyond that, districts and employees will have increasing levels of difficulty transitioning from the K-12 benefits business model to the state employees' benefits business model. These key impacts include:

1. Reduced district and employee participation in policy and strategic decision-making.
2. Loss of decision-making authority in areas of benefit plan design, selection of benefit plan sponsors and carriers, and reduced scope, relative value, and diversity of the available benefit portfolio.
3. Increased costs associated with eliminating the employee prorated premium levels, paying full contributions for employees who waive coverage, and contributing to a consolidated purchasing system funding pool that allocates available funds to the PEBB program instead of at the individual districts.

From the perspective of the Health Care Authority, the addition of the full K-12 employer system to the PEBB program presents large fiscal and infrastructure challenges, that in light of the state's current economic status, may be insurmountable. These challenges include:

1. Significant upfront funding to achieve targeted reserve levels for increased enrollment in the Uniform Medical Plan.
2. High risk of underestimating future medical costs due to a lack of claims experience data for the K-12 population.
3. Infrastructure upgrades necessary to manage the full scope of basic benefits established for school employees by state law.

From the perspective of state policy makers, this strategy addresses the goals set for a consolidated purchasing strategy in the following ways:

1. **Equitable access** to health benefits for all emloyees and their dependents. This strategy does not address the large variation in employee premiums among employee groups (certificated, classified, administrative, management) and between employees who do and do not cover their dependents.
2. **Transparency**. Additional transparency into benefits system costs and quality will be gained through increased access to employee claims experience, and exchange of quality and cost information among employers, benefits purchasing system administrator, benefits carriers, and employees.

3. **Cost-effectiveness**. Reduced costs are anticipated through administration simplification in this strategy. More importantly, reducing the current K-12 medical plan relative value down to the Uniform Medical Plan value results in a cost reduction of approximately 8% to 10% and substantial cost savings to the state and districts, but shifts the costs to a large segment of district employees. Some of these savings are offset by increased costs to the state, districts, and employees for those members currently enrolled in medical plans that have a lower value than PEBB plans.

   Overall, net savings to the state and districts are anticipated, but increased costs for the employees. Increasing the relative value of UMP a little more, and expanding the lower end of the PEBB medical plans could provide a better balance of cost-effectiveness across the system.

4. **Shared responsibility.** This strategy limits shared responsibility among the state, districts, and employees in terms of decision-making, with the state assuming greater decision-making authority.

5. **System wide integration**. This strategy achieves increased system wide integration across the districts, but stops short of achieving improvements in equitable access to health coverage and consistency of benefit design and delivery.

6 **Value-based purchasing**. The PEBB program has added three consumer-directed health plans for 2012 (which exist in some school districts today) and an enhanced accountability plan for 2013, increasing the sophistication of the portfolio and creating options better customized to client needs. These options include incentives and design features that promote personal responsibility for improving and maintaining members' health status and increased engagement in using their benefits.

CONCLUSION

It is the Health Care Authority's conclusion that a strategy to develop a consolidated purchasing system using the existing PEBB Program, even with reasonable modifications, poses serious financial risks to the PEBB Program and the state, while achieving only limited improvements in areas important for the Governor and Legislature. Attempting to blend two employees' benefits system business models will negatively impact both benefits systems, while achieving a diminished level of potential gain in quality and affordability for employees.

RECOMMENDATIONS

A. A separate single community-rated statewide risk pool should be established by the Legislature if the decision is made to authorize a consolidated Public School Employees' Benefits Purchasing System. The separate K-12 risk pool will be closely coordinated with the state employees' risk pool to ensure common evidence-based medical policies are consistently applied and appropriately leverage state purchasing priorities.

B. High risk of underestimating future medical costs due to a lack of K-12 public school employee claims experience data for the K-12 population poses an untenable risk to a combined risk pool. The Health Care Authority recommends that the Legislature not establish a consolidated public school employees' benefits purchasing system that incorporates public school employees into the existing single community-rated risk pool used for state employees or utilizes the Public Employees' Benefits program as the exclusive source of employee insurance benefits for public school employees.

SCENARIO: SEPARATE PUBLIC SCHOOL EMPLOYEES' BENEFITS PURCHASING SYSTEM

OVERVIEW

Based on the conclusion and recommendation outlined for the previous Scenario, the Health Care Authority completed a design for a new consolidated public school employees' benefits purchasing system as described in this Scenario. The major design components developed are:

1. Risk Pool and Insurance Risk
2. Governance Structure
3. Eligible Entities and Individuals
4. Benefit Plan Portfolio
5. Revenue Sources and Cost Sharing Responsibilities
6. Participation Requirements

DESIGN GOALS

During the early stages of the project, the general intent statements and project goals developed in the project scope document were further refined to add additional clarity to the desired outcomes for the project. This effort resulted in the following set of goals and associated key points:

A. **Cost-effectiveness and administrative efficiency**

   1. Program administration and operations are designed to take advantage of purchasing leverage, process simplification through system wide consistency and reduced duplication, and effective use of technology.
   2. Anticipated avoidable future costs will result in lower premium rates and will likely accumulate in increasing amounts as the consolidated program measures subscriber experience and stabilizes.
   3. The scope of the current Health Care Authority project does not cover potential cost savings associated with incurred costs of actual benefit utilization.

B. **Equal access to health benefits by all employees**

   1. Public funds are allocated as an employer contribution through a methodology that is consistently applied regardless of employing agency, employee group, or whether an employee does or does not cover dependents.
   2. Employee eligibility is determined by each school district in accordance with district policy.
   3. Premium contributions for the employee and dependents are set through a rate structure that is consistently applied for all employees.

4. All participating districts and employee groups have access to a common benefits plan portfolio with a sufficient number of plans of differing types and relative values to provide each employee group the ability to package a subset of plans that affords individual employees a meaningful choice based on individual preferences and needs.
5. In support of consumer engagement and accountability, each participating employee is required to pay a share of the local district premium obligation regardless of district or employee group.

C. **Transparency**

1. Budget Management:
    a. Detailed reporting of health benefits funding by revenue sources.
    b. State allocation
    c. Local levies
    d. Employee out-of-pocket
    e. Others such as grants, federal monies, etc.
2. Detailed reporting of health benefits costs by expenditure category:.
    a. Health care expenses
    b. Employing Agency expenses
    c. Benefits Administrator expenses
    d. Contracted Carrier expenses
3. Purchaser Benefits Management:
    a. Routine (annual or more frequent) employee population and health plan experience data submission to Benefits Administrator segregated by individual district.
    b. All districts, or their representatives, have access to the benefit plan designs and established employee premium sharing obligations for all benefits plans and family tiers prior to bargaining groups packaging a subset of offerings for their represented employees.
    c. Detailed benchmarking of benefits program annual performance.
4. Consumer and Provider Engagement:
    a. All employees have access to information describing the benefit plans available to them and the established employee premium sharing obligations prior to making decisions regarding participation and individual plan selection during open enrollment.
    b. Health plan and provider cost and quality information is available to enrollees and providers to assist in effective benefits utilization and cost control.

D. **Integrated systems**

Creating a consolidated purchasing system to improve cost-effectiveness, equity and transparency involves organizing the K-12 public employees' benefits system to enable the State and districts to act collaboratively as a single integrated organization rather than a collection of independently functioning benefits programs. Transitioning to greater system integration involves moving strategy, policy, and benefit design decision-making responsibility and authority from the individual district level to the consolidated program governance level, and centralizing or standardizing key management systems and processes.

E. **Value-based purchasing strategy**

1. Strategy Outcomes:
    a. Health status improvement
    b. Cost trend management
    c. Positive member experience & satisfaction
    d. Health care quality improvement
2. Strategy Approach:
    a. High engagement by the Health Care Authority, school districts and educational service districts, members, network providers, and contracted health plans.
    b. Shared financial accountability for cost trend management on the part of the state, employers, members, network providers, and contracted health plans.
    c. Dual focus on individual healthy lifestyles, management of chronic disease, and effective utilization of available benefits, including wellness and preventative services.

DESIGN ASSUMPTIONS

Early in the project, the design team brainstormed the underlying assumptions to guide the proposal design. These assumptions were shared with the project teams and were frequently referenced throughout the design process to focus the design outcomes.

A. **Shared responsibility for funding**

The State, local districts, and public school employees will share responsibility for funding the consolidated public school employees' benefits program, with all parties making a financial contribution.

B. **Shared responsibility for cost control**

The State, districts, public school employees, contracted benefits plans, and contracted providers will share responsibility for controlling the costs of the consolidated public school employees' benefits program through active engagement in managing the program, individual health and wellness promotion, and cost-effective benefit utilization.

C. **Provisions of basic benefits**

The responsibility for determining the basic benefits provided to employees will remain at the district bargaining unit level. In the event the consolidated program does not offer the full set of basic benefits defined in RCW28A.400.270 to districts (e.g. medical, dental, vision, group term life, and group long term disability insurance), the districts will be responsible for separately securing basic benefits they agree to provide to employees.

D. **Benchmark plan**

A benchmark plan will be defined from which a portfolio of plans can be developed to provide a manageable number of plan offerings that offer a range of affordable options. This will enable employees of differing income levels and employees who do and do not cover dependents to access employer insurance benefits. The WEA-Premera Plan 2 will be used to model a comparable benchmark plan.

E. **Premium tiers**

The employer will contribute a fixed percentage of the premiums for employees and a separate fixed percentage for dependents based on an established dependent marginal contribution.

An acceptable employer contribution range for the employee-only tier in a benchmark plan is 75%-90%.

An acceptable employer contribution range for the dependent marginal contribution in a benchmark plan is 50%-75%.

F. **Benchmark plan cost-neutrality**

The benchmark plan design is set to achieve cost neutrality with current available revenue. No administrative cost savings or savings due to reduced cost of medical care or other reduced benefit utilization are modeled into the benchmark plan.

1. RISK POOL AND INSURANCE RISK

RISK POOL

In this scenario, the new risk pool will include the following three groups:

1. The groups of employees of school districts and educational service districts that are currently within the state employees' community-rated risk pool described in 41.05.022 RCW.
2. Other groups of employees of school districts and educational service districts that are required to purchase health benefits through the consolidated K-12 public school employees' benefits purchasing system at the purchasing system's inception.
3. Other groups of employees of school districts and educational service districts defined by the enabling legislation that are allowed to purchase health benefits through the consolidated K-12 public school employees' benefits purchasing system on a voluntary basis.

Note: Further analysis is required to determine the scope of financial impacts that would result from the transfer of K-12 Pre-Medicare Retirees from the public employees' risk pool to a separate risk pool for a consolidated K-12 public school employees' benefits purchasing system. This analysis is underway. If the decision is to transition Pre-Medicare retirees to the K12 consolidated benefits purchasing system, implementation will occur the second benefit year.

INSURANCE RISK

A critical decision point for the consolidated K-12 public school employees' benefits purchasing system design is the determination of the insurance risk model, i.e., to self fund or fully insure the health benefits. In evaluating feasible options related to the insurance risk arrangement for a separate public school employees' benefits purchasing system, the Health Care Authority explored two critical factors that had to be taken into account:

1. Data – the need for a complete data set to feed a financial projection model robust enough to accurately predict expected costs.
2. Reserve Funds - the availability of the cash infusion necessary to adequately fund the reserves required to support a self-insured system.

Based on the Health Care Authority's assessment of the two critical factors, this report only presents one design proposal for insuring risk.

DATA SUFFICIENT TO MODEL EXPECTED COSTS

A reliable financial projection model requires two key components – the final definition of the design of the system and a complete set of detailed claims level data for that system. Neither of these two cornerstones exist for a consolidated K-12 public school employees' benefits purchasing system. There

are constraints on the data gathering process that impact the ability to build a model to forecast the expected costs under a unified system. Currently, the data is being gathered from many different sources (various local school districts, Office of Superintendent of Public Instruction (OSPI), Washington State Information Processing Cooperative (WSIPC), and various carriers. Given the variety of sources, the data set available for this project is inconsistent, incomplete, and it is not at a sufficient level of claims detail for the in-depth analysis required. The quality of a financial projection model built using the current incomplete and limited data would produce questionable results. Without an accurate way to model expected costs, the decision to self-insure a consolidated K-12 public school employees' benefits purchasing system would create considerable downside risk. Claims experience could potentially be far greater than projected which could require an in-flow of additional funding resources after initial startup.

RESERVES

Self-insurance requires actuarially sound calculations to be made of the reserve funds necessary to cover incurred but not reported expenses (IBNR) and to account for potential adverse trends (typically through a premium stabilization reserve or PSR). The amount of the reserves required to adequately fund a self-insured system depends in large part on the systems' experience with health care costs and the tolerance for risk of the entity self-insuring. If the entity has a high risk tolerance, it may decide to carry a lower reserve balance, or conversely, if the entity has a low tolerance for risk, it may want a higher reserve balance.

A general rule of thumb for appropriate levels for an IBNR reserve is in the range of 15%-20% of expected annual costs. A typical PSR is in the range of 10% of expected costs. Combined, an appropriate reserve requirement would be approximately 25% of expected costs. For a consolidated K-12 public school employees' benefits purchasing system with medical expenditures of $1.09 billion, a reserve of approximately $275 million would be appropriate. Given the current State fiscal situation, finding the funding necessary to establish the required reserves would be a difficult obstacle to overcome.

RECOMMENDATION

Due to the current absence of the data necessary to develop a reliable financial projection model and upfront funding for adequate reserve levels for self-insured benefits plans, initially all benefit plans in the consolidated K-12 public school employees' benefits purchasing system will be fully-insured. The system design will retain the flexibility to allow transition of any or all of the benefit plans to self-insured status at a later date as experience is gained and program fiscal status allows.

IMPACTS TO CURRENT K-12 PUBLIC SCHOOL SYSTEM

Creation of a single community-rated risk pool that includes all K-12 public school employees of participating districts will provide the basis upon which the Health Care Authority will design and

competitively procure a benefit plan portfolio. The result will be a substantial reduction in the number of benefit plans that currently exist as a result of 300 plus districts purchasing health benefits through a variety of sources to serve the specific arrangements made with approximately 1,200 different employee bargaining units and other employee grouping arrangements.

The health plan sponsors and carriers currently providing this large array of benefit plans will be placed in a position of participating in the Health Care Authority's competitive procurement to vie for the K-12 public school employee business with the associated potential of gaining or losing market share. In addition, private contractors and consultants that provide broker services to school districts will lose some portion of revenue generated from the procurement of benefit plans for districts.

It is anticipated that the State, districts and employees will benefit from moving to a single community-rated risk pool of the size involved as a result of the purchasing power the Health Care Authority will present in a single competitive procurement for the full system wide benefit portfolio. Factors that will influence the premium levels within the benefit plan portfolio include changes in the makeup of administrative cost centers under a consolidated design, greater stability in the risk pool, and a competitive bidding process for carrier selection on an established re-occurring schedule.

Districts that currently function under a self-insured risk management arrangement will no longer be responsible for the responsibilities and activities associated with self-insuring employee benefits, except in the event provisions are made for non-participation in the K-12 public school employees' benefits purchasing system and the district is granted an exception.

Concerns have been raised previously about the potential for excessive risk management costs under a fully-insured arrangement in comparison to a self-insured arrangement. Because the full portfolio will be procured through a transparent competitive procurement process, carrier risk management costs will be scrutinized as an important element of the evaluation and selection process.

REQUIRED STATUTORY CHANGES

A. It will be necessary for the legislature to authorize the creation of a separate community-rated risk pool for school employees receiving health benefits purchased through the consolidated K-12 public school employees' benefits purchasing system. At the same time the legislature should remove this group of employees from the text of 41.05.022 RCW as it relates to the public employees' risk pool.

B. The Public Employees' Benefits' Board composition defined in 41.05.055 RCW will need to be amended to remove the position designated for a member who represents an association of school employees and to make other adjustments to retain the nine member composition and voting rights.

CONTINUING WORK

There is a high level of interest around the disposition of risk pool placement for eligible retired and disabled school employees not eligible for parts A and B of Medicare, frequently referred to as the K-12 pre-Medicare retirees and disabled employees. There are many complexities surrounding the placement of this group with potential measurable impacts to both risk pools. The Health Care Authority was unable to perform a thorough evaluation to identify the nature and scope of potential impacts, model the financial impacts, and develop appropriate recommendations within the time available to complete this report. As a result no detailed analysis is presented for legislature consideration. The Health Care Authority will continue work to complete a proper analysis and will present a recommendation at the time the analysis is completed.

2. GOVERNANCE STRUCTURE

OVERVIEW

Chapters 28A.400 and 41.05, RCW define the roles and responsibilities of school districts and educational service districts and the Health Care Authority pertaining to public school employees' insurance benefits.

In the existing K-12 environment, school districts and educational service districts develop an employee benefit plan to be used by the district for distributing fringe benefit subsidies to employees, including the method of determining employee coverage and the amount of employer contributions, as well as the characteristics of benefit providers and the specific benefits or coverage offered. The basic benefits offered are determined through local bargaining. The board of directors of the districts makes available insurance benefits for employees and their dependents through contracts with private carriers, with the Health Care Authority pursuant to the approval of the Authority Director, or through self-insurance or self-funding, or in any other manner authorized by law.

The Health Care Authority's duties include administering health care benefit programs for active and retired or disabled state employees, retired or disabled school employees, and other employing agencies' employees and retirees through a voluntary contracting arrangement. For those districts entering into voluntary contracts with the Health Care Authority for employee benefits, the districts are defined as "employing agencies" and their employees fall within the definition of "employee" for purposes of Health Care Authority administration of employee health benefits.

The Health Care Authority is also responsible to coordinate state agency efforts to develop and implement uniform policies across state purchased health care programs that will ensure prudent, cost-effective health services purchasing, maximize efficiencies in administration of state purchased health care programs, improve the quality of care provided through state purchased health care programs, and reduce administrative burdens on health care providers participating in state purchased health care programs. "State purchased health care" includes medical and health care, pharmaceuticals, and medical equipment purchased with state and federal funds by local school districts.

Beginning July 1, 2011, the Health Care Authority merged with the Medicaid Purchasing Administration and became the single state agency for purposes of consolidated state health purchasing.

Consolidating the employee benefit purchasing activities of over 300 districts into a single statewide system necessitates the realignment of multiple benefit decision processes from the individual district level to the consolidated program level. For the majority of districts this will affect existing bargaining activities with employee representatives in one or more of the following areas:

1. Definition of full-time status for employee positions.
2. Types of benefits covered.
3. Employee eligibility determination.

4. Participation in a consolidated purchasing system under a voluntary non-participation arrangement (if provisions are made by the Legislature for non-participation).
5. Benefit program eligibility standards.
6. Benefit plan design, including point of service employee cost-sharing arrangements.
7. Benefit plan sponsors and carriers,
8. Employer contribution to premium.
9. Employee contribution to premiums for self coverage.
10. Employee contribution to premiums for dependent coverage.

Transition of the decision processes to the Health Care Authority can take several forms. For purposes of this report four governance structure options were explored in which the participating districts retain the role of employer, the Health Care Authority performs the role of health benefits purchasing system administrator on behalf of districts, and the roles of local bargaining and existing bargaining units vary. The four options are:

1. Informal K-12 Public School System Participation.
2. Structured K-12 Public School System Representation on an Advisory Group.
3. Structured K-12 Public School System Representation on Standing Committees.
4. Structured K-12 Public School System Participation on a Public School Employees' Benefits Board.

In all four options,

1. The districts retain decision authority as the employing agency for:
    a. Definition of full-time status for employee positions.
    b. Types of benefits covered.
    c. Employee eligibility determination.
    d. Participation in a consolidated purchasing system under a voluntary non-participation arrangement (if provisions are made by the Legislature for non-participation).
2. The Health Care Authority assumes full decision authority for:
    a. Benefits purchasing system eligibility standards.
    b. Benefit plan design, including point of service employee cost-sharing arrangements.
    c. Benefit plan sponsors and carriers.
    d. Employer contribution to premiums.
    e. Employee contribution to premiums for self coverage.
    f. Employee contribution to premiums for dependent coverage.

THE OPTIONS

From a decision-making perspective, the four options are designed to differ in the degree of involvement districts and local collective bargaining units have in supporting the Health Care Authority as it performs its role as the health benefits purchasing system administrator on behalf of districts. The options provide a spectrum from informal support to delegated decision authority as members of a legislatively defined policy board.

Underlying all options is acknowledgement of the Health Care Authority's statutorily designated role as the single state agent for purchasing health services (RCW 41.05.022) and its responsibilities to:

1. Strive to integrate purchasing for all publicly sponsored health services in order to maximize the cost control potential and promote the most efficient methods of financing and coordinating services;
2. Consult regularly with the governor, the legislature, and state agency directors whose operations are affected by implementation of this role; and
3. Ensure the control of benefits costs under managed care competition by adopting rules to prevent employers from entering into an agreement with employees or employee organizations when the agreement would result in increased utilization in public employees' benefits board plans or reduce the expected savings of managed competition.

Several provisions of RCW Chapters 28A.400, 41.05, 41.56, and 41.59 are pertinent to these options. It is assumed the Legislature amends existing state laws relating to K-12 public school employees' health benefits to:

1. Transfer full decision authority to the Health Care Authority in the following areas:
    a. Benefit purchasing system eligibility standards.
    b. Benefit plan design, including point of service employee cost-sharing arrangements.
    c. Benefit plan sponsors and carriers.
    d. Employer contribution to premiums.
    e. Employee contribution to premiums for self coverage.
    f. Employee contribution to premiums for dependent coverage.
2. Remove employee health benefits from the scope of collective bargaining for all school employee groups to the degree necessary to transition applicable decision-making authority to the consolidated public school employees' benefits purchasing system governing structure.

OPTION 1 – INFORMAL K-12 PUBLIC SCHOOL SYSTEM PARTICIPATION

This option places the greatest emphasis on achieving the State's health care priorities for quality, affordable health care and the need to move state purchased health care programs forward into

meaningful health care reform in a planned and coordinated manner. **To maximize this effort, the Health Care Authority has full authority and responsibility for the management and performance of the K-12 consolidated health benefits purchasing system.**

Individuals and organizations representing school districts, educational service districts, and K-12 public school employees will retain avenues to participate in the development of strategy, policy, and rules relating to the consolidated employees' health benefits purchasing system through interactions with the Governor and Legislature and through the state's administrative rulemaking process.

OPTION 2 – STRUCTURED K-12 PUBLIC SCHOOL SYSTEM REPRESENTATION ON AN ADVISORY GROUP

In this option the described role and responsibilities of the Health Care Authority do not change from Option 1. An additional avenue for district and employee participate in the development of strategy, policy, and rules related to the consolidated employees' health benefits purchasing system is afforded in the form of a standing advisory group to the Health Care Authority. **The purpose of this group is to provide a structured forum for stakeholder group dialogue and information exchange between the Health Care Authority and the K-12 public school system. The advisory group does not have decision-making authority related to the consolidated public school employees' benefits purchasing system.**

During the preparation of this report, the Health Care Authority reached out to a broad representation of the K-12 public school system to participate on a project advisory team. A large majority of the individuals and organizations contacted responded positively and additional persons requested to participate as they became aware of the project. It is anticipated that a similar representative advisory team with equally active participation can be organized and function on an ongoing basis.

OPTION 3 – STRUCTURED K-12 PUBLIC SCHOOL SYSTEM REPRESENTATION ON STANDING COMMITTEES

Moving from an informal participatory structure, Option 3 establishes designated representation of districts, employee groups, and employees on one or more employee benefits standing committees, each of which has a defined scope and responsibilities established by administrative rule. The standing committee(s) functions under the direction of the Health Care Authority director or designee. Initially, it is envisioned that standing committees will be beneficial for successful implementation and ongoing management of the K-12 consolidated purchasing system in the following areas:

1. Strategy and policy development – Focus on providing meaningful recommendations aimed at minimizing the financial burden which health care poses for the state, districts, and employees while at the same time allowing the purchasing system to provide the most comprehensive health care options possible. **This committee is the conduit for K-12 public school system participation in development of recommendations that go directly to the Health Care Authority.**

2. Value-based purchasing – Focus on evidence-based health care, prevention/wellness/chronic disease management, high performing provider systems, etc.
3. Participant engagement – Focus on education, outreach, and use of incentives and disincentives to influence positive behavior among members, employers, health plans, and providers related to improvement and maintenance of individual health status and effective utilization of covered benefits.

A larger advisory committee as described in Option 2 could be added in this option to support the standing committees and to provide another forum for input to the Health Care Authority.

OPTION 4 –
STRUCTURED K-12 PUBLIC SCHOOL SYSTEM PARTICIPATION ON A PUBLIC SCHOOL EMPLOYEES' BENEFITS BOARD

Option 4 is in keeping with the Section 213 directive for the Health Care Authority to propose the structure of a permanent governing group to provide ongoing oversight to the consolidated pool, in a manner similar to the Public Employees' Benefits Board functions for employee health benefits, including statutory duties and authorities of the board.

In this option, a Governor appointed Public School Employees' Benefits Board composed of 13 voting members is formed within the Health Care Authority with delegated decision-making authority defined by statute. The board has representation from the state, districts, and employees and assumes responsibility for the areas of local decision authority and collective bargaining identified above that are transferred to the Health Care Authority through the creation of the consolidated school employees' benefits purchasing system. The board serves as the primary conduit through which the K-12 public school system interacts with the consolidated benefits purchasing system.

The board duties and authorities include:

1. Develop by-laws for conducting board business.
2. Study all matters connected with provision of adequate benefit plan coverage on the best basis possible with regard to the welfare of employees and affordability for districts and the state.
3. Develop employee benefits plans that include comprehensive health care benefits for employees.
4. Authorize premium contributions for an employee and the employee's dependents in a manner that encourages the use of cost-efficient health care systems.
5. Determine the terms and conditions of purchasing system participation, including establishment of criteria for employing agencies and individual employees.
6. Establish penalties to be imposed when the eligibility determinations of an employing agency fail to comply with established participation criteria.
7. Authorize exceptions to mandatory participation in accordance with established terms and conditions (if provisions are made by the Legislature for non-participation).

8. Establish penalties to be imposed when the employing agency fails to comply with established participation criteria.
9. Provide consultation to the Health Care Authority director during the development of criteria and evaluation and selection of benefit plan carriers and third party administrators.

The board may establish standing committees and ad hoc workgroups to conduct research, engage stakeholders, and make recommends that support the work of the board to ensure consistent evidence-based medicine policy and to leverage policy development jointly with the Public Employees' Benefits Board to ensure policies are applied consistently.

The proposed Public School Employees' Benefits Board composition to be appointed by the Governor consists of:

1. Three members from associations representing district-level administrators.
2. One member from an association representing school boards of directors.
3. One member from an association representing certificated employees.
4. One member from an association representing classified employees.
5. One member designated to represent employees as a collective group that is not otherwise affiliated with an employee association.
6. One at-large active employee.
7. Two members with expertise in employee health benefits policy and administration, one of which is nominated by an association representing school business officials and one at-large member with expertise in health care policy.
8. One representative of the Health Care Authority.
9. One representative of the Office of Financial Management.
10. One representative of the Office of the Superintendent of Public Instruction.

The board will assume its official duties and be integrated into the work of the Health Care Authority at the point the full complement of members have been appointed by the Governor and the board completes an orientation to the purchasing system structure and the board's duties and responsibilities. Initial formation of the board will not impede the work the Health Care Authority must perform in order to successfully complete the implementation of the consolidated benefits purchasing system by the targeted date set by the Legislature.

RECOMMENDATION

Implement Option 4 – Structured K-12 Public School System Participation on a Public School Employees' Benefits Board as an effective means to transition elements of employer/employee bargaining of employee health benefits from the local district level to a governing board with district and major employee group representation.

IMPACTS TO CURRENT K-12 PUBLIC SCHOOL SYSTEM

It is assumed the Legislature amends existing state laws relating to K-12 public school employees' health benefits to:

1. Transfer full decision authority to the Health Care Authority in the following areas:
    a. Benefit purchasing system eligibility standards.
    b. Benefit plan design, including point of service employee cost-sharing arrangements.
    c. Benefit plan sponsors and carriers.
    d. Employer contribution to premiums.
    e. Employee contribution to premiums for self coverage.
    f. Employee contribution to premiums for dependent coverage.
2. Remove employee health benefits from the scope of collective bargaining for all school employee groups to the degree necessary to transition applicable decision-making authority to the consolidated public school employees' benefits purchasing system governing structure.

REQUIRED STATUTORY CHANGES

It will be necessary for the legislature to:

1. Add provisions to 41.05 RCW authorizing the creation of a Public School Employees' Benefits Purchasing System governing board, and specifying the board appointing authority, the board composition, and the board duties.
2. Amend applicable sections of 28A.400 RCW to transfer full decision authority to the Health Care Authority for the specified aspects of employees' benefits system design and rate setting.
3. Amend applicable sections of 41.56 RCW and 41.59 RCW to remove employee health benefits from the scope of collective bargaining for all school employee groups to the degree necessary to transition applicable decision-making authority to the consolidated public school employees' benefits purchasing system governing structure.

3. ELIGIBLE ENTITIES AND INDIVIDUALS

OVERVIEW

Defining the entities that will be eligible to receive health benefits through the consolidated K-12 public school employees' benefits purchasing system is an essential step in the system design. Drawing on existing practices within the array of K-12 employee benefits programs and the structure of the Public Employees' Benefits Board program, an eligibility structure is proposed that takes advantage of workable elements in a way that is tailored to the shared responsibilities of the State and local districts in their respective roles.

EMPLOYER GROUPS

The Health Care Authority was asked to evaluate two employer groups for possible inclusion in the consolidated K-12 public school employees' benefits purchasing system— public school districts and educational service districts. Both groups currently participate in the Public Employees' Benefits Board program on a voluntary basis as groups covered by the risk pool for state employees. An analysis of the movement of each group demonstrated no compelling barriers to moving them to a separate risk pool established for a consolidated K-12 public school employees' benefits purchasing system as discussed in section 1— Risk Pool and Insurance Risk.

EMPLOYEE GROUPS

Categories of employee groups in the K-12 public school system are well established and no reason was found to re-define these categories for purposes of establishing eligibility standards for the consolidated K-12 public school employees' benefits purchasing system. The defined categories are:

1. Certificated employees
2. Classified employees
3. Administrative employees
4. Management employees

Special service employees such as licensed health professionals are considered as an eligible employee group if not otherwise included in the categories listed above.

In addition to the above employee groups, the consolidated benefits purchasing system should provide coverage for COBRA eligible post-employees to enable districts to fulfill their obligations to these individuals.

EMPLOYEES

DEFINING FULL-TIME STATUS FOR PURPOSES OF BENEFIT ELIGIBILITY

In the current array of K-12 employee health benefits programs, the district as the employer has the authority and responsibility to establish the eligibility criteria for health benefits to be consistently applied to its employees and to determine employee eligibility for benefits coverage based on the criteria. Through interviews with school officials and discussions with the project Advisory Team it became apparent that there is a mixture of consistent practices and variations in practice between districts.

It is common practice among districts to define the full-time status of an employment position based on a variety of factors including the nature of the work, requirements of state law, and collective bargaining agreements. There is not a single definition of full-time status that equates to an annual number of hours worked (such as 2080) that is uniformly applied to all employment positions. Reported practices include variations in hours per year, hours per week, and hours per day. Regardless of the defining factor, each employment position has a defined full-time status that becomes the basis upon which benefit eligibility is determined for an incumbent employee.

The eligibility threshold to qualify for health benefits coverage varies between districts. The majority set the threshold at 0.5 FTE or higher, but some districts reported setting a lower threshold.

Under current rules for school district and educational service district participation in the Public Employees' Benefits Board program, the employer retains the authority and responsibility to establish the definition of full-time status for each employment position and to then determine the actual FTE status of the incumbent employee when applying the PEBB program eligibility threshold requirement of 0.5 FTE or higher. The rules also provide for a district to negotiate different eligibility criteria when negotiating a contract with the Health Care Authority for participation in the PEBB program.

Retaining the employer role of the districts is an important element of the consolidated K-12 public school employee benefits purchasing system design. As such, continuing the authority and responsibilities of the districts that now exist in relation to employee eligibility is manageable and avoids major impacts to employee access to health benefits that may occur as a result of the Health Care Authority redefining the criteria that constitutes full-time status for public school employment positions.

ELIGIBILITY CRITERIA FOR PARTICIPATION IN A CONSOLIDATED BENEFITS PURCHASING SYSTEM

Past experience with the PEBB program has demonstrated the difficulties and complexities associated with overly flexible eligibility criteria for participation in a consolidated benefits purchasing system serving the number of employees and employing agencies involved with the K-12 public school system. In order to include a reasonable level of control and administrative simplicity in the design of the consolidated K-12 public school employee benefits purchasing system, the impact of setting the eligibility standard for participation at 0.5 FTE was evaluated.

The Milliman Inc. analysis of data collected from districts and data received from the Office of the Superintendent of Public Instruction estimates there were approximately 3,000 employees categorized as less than 0.5 FTE for purposes of benefits eligibility, within a total employee population of approximately 130,000 (2.3%), at the defined sample point in 2010.

Discussions were held with school district officials to assess the implications of these 3,000 employees becoming ineligible to receive health benefits under the consolidated purchasing system. Clearly these employees are considered a valuable resource to the districts that employ them and in many cases the district officials reported these employees are working solely to access health benefits and expend their entire paychecks to pay the benefit premiums. Because of the number of employees involved, the district officials proposed there be a grandfathering arrangement specifically for employees in place at the time the consolidated benefits purchasing system is implemented. Under the grandfathering arrangement, the employing district would provide an employer contribution equivalent to that set for 0.5 FTE status and the grandfather arrangement would be limited to a set number of years.

In the end, the combination of a firm 0.5 FTE eligibility standard and a grandfathering arrangement appears to be a feasible and reasonable approach that overcomes identified negative impacts.

ELIGIBLE DEPENDENTS

To develop a proposed list of dependents eligible for benefit coverage under the consolidated K-12 public school employees' benefits purchasing system, existing dependent types defined in state statutes and administrative rules applicable to public school employees in the PEBB program were identified. Four dependent types noted were:

1. Legal Spouse
2. Children up to age 26
3. Children of any age with disabilities, mental illness, or intellectual or other developmental disabilities
4. Registered domestic partners, as defined in RCW 26.60.020.

Members of the project advisory team reported that, as employers, school districts and educational service districts have the authority to define dependent types covered under existing employee benefits programs in the K-12 public school system; they suggested that the consolidated K-12 public school employees' benefits purchasing system include dependent types commonly covered by districts that are not currently covered by the PEBB program. Of particular interest are domestic partners who may not fall within the definition used by the PEBB program.

The data collected from school districts for this project did not contain sufficient detail to develop an aggregate list identifying the common types of dependents covered by existing district employee benefits programs. One source provided the following list as an example of dependents covered:

1. K-12 opposite sex domestic partners (Registered or not)

2. K-12 unregistered same sex domestic partners
3. Children of both 1 and 2 above
4. Non-parental custodians (legal guardianship)
5. Medical support order
6. Medical assistance
7. Leave of absence
8. Special open enrollment
9. Surviving dependents are covered for 12 months at no cost.

As a result of not having sufficient information to decide otherwise, the Health Care Authority's list of dependent types is limited to the four categories currently specified in 41.05 RCW.

RECOMMENDATIONS

A. The consolidated employees' health benefits purchasing system covers all K-12 public school districts and educational service districts.

B. The following employee groups are covered by the consolidated employees' health benefits purchasing system:

   1. Active certificated employees.
   2. Active classified employees.
   3. Active administrative employees.
   4. Active management employees.
   5. Active special services employees (health professionals).
   6. COBRA eligible post-employees as further defined.
   7. Other groups allowed by authorizing statute.

C. An employee in a covered employee group is eligible for benefits through the consolidated purchasing system upon employing agency determination that the employee qualifies as a 0.5 FTE or greater based on agency policy in effect prior to the benefit year in which the employee will be covered.

D. A district may continue to obtain employee health benefits through the consolidated purchasing system for an employee with a status less than 0.5 FTE on a grandfathered basis for a maximum of 5 benefit years beyond the initial consolidated purchasing system benefit year.

E. The following employee groups are covered by the consolidated employees' health benefits purchasing system:

1. Spouses.
2. Registered Domestic partners.
3. Children up to age 26 and disabled dependents.
4. Others designated by the authorizing statute.

IMPACTS TO CURRENT K-12 PUBLIC SCHOOL SYSTEM

With the incorporation of a grandfathering provision to enable districts to continue to provide health benefit coverage for incumbent employees that otherwise would be ineligible due to their FTE status, the potential negative impact on these individuals can be alleviated.

For those districts that currently provide coverage to employees with an FTE status below 0.5 FTE, future employment decisions will have to take into account the fact that employees hired into a position at a FTE status less than 0.5 FTE will not be able to provide benefits coverage to those employees.

Unless the Legislature desires to provide benefits coverage to types of dependents other than those currently specified for public school employees in 41.05 RCW, other categories currently covered by school districts will not be covered in the consolidated public school employees' benefits purchasing system.

REQUIRED STATUTORY CHANGES

New provisions will need to be added to 41.05 RCW to define eligible entities and individuals that are authorized to participate in the consolidated public school employees' benefits purchasing system.

4. BENEFIT PLAN PORTFOLIO

OVERVIEW

The design of the benefit plan portfolio for the consolidated K-12 public school employees' benefits purchasing system is paramount to achieving a purchasing system that has the depth to provide access to affordable, comprehensive health care services while maintaining a manageable size. Five primary outcomes were used to guide the proposed benefits portfolio design:

1. Provide a sufficient number of plans with sufficient variation in relative value to provide access to health insurance across a large of portion of the spectrum of income levels within the K-12 public school system.
2. Provide access to a comparable range of plan relative values as exists in the current K-12 employees' benefits array with employee cost-sharing levels proportional to the value of the plan.
3. Provide at least one comprehensive plan design to be offered on a statewide basis that is comparable to an existing benefits plan with substantial enrollment.
4. Assure the relative value of the statewide comprehensive plan design is competitive with the relative value of the state employees' comprehensive statewide plan (Uniform Medical Plan) and is consistent with point of service cost-sharing levels found in the Washington large employer market and among large public school employers across the nation.
5. Structure the implementation of the consolidated benefits purchasing system to assure medical/Rx, dental, and vision benefits are offered at the onset. Life and long-term disability benefits should be offered at the point the consolidated benefit purchasing system has comparable offerings to those currently available to K-12 public school employees and has an infrastructure that can support these benefit offerings on a broad public school participation basis.

Three core aspects of benefit portfolio design formed the basis upon which the Health Care Authority developed its proposal:

1. Provision of Covered benefits.
2. Types, numbers and relative value range of benefits plans.
3. Benchmark plan.

PROVISION OF COVERED BENEFITS

Subsection (3) of 28A.400.270 RCW defines five insurance benefits as the "basic benefits" for purposes of K-12 public school employee health benefits coverage. The five are:

1. Medical (including pharmacy).
2. Dental.

3. Vision.
4. Group term life.
5. Group long-term disability.

In order to evaluate the Health Care Authority's capacity to offer these five insurance benefits through a consolidated purchasing system serving the full contingent of K-12 public employees, each benefit was considered on its own to determine whether the necessary detailed design and procurement activities could be completed and the necessary infrastructure put in place to support effective administration of the benefit. The analyses of all five benefits resulted in the conclusion that the medical, dental, and vision benefits could be in place for a 2013-14 school year consolidated employees' benefits purchasing system implementation.

Conversely, the analyses of the life and long-term disability benefits resulted in the conclusion that these benefits could not be properly implemented for the 2013-14 school year. Two major issues were identified that lead to this conclusion:

1. A full scale detailed design of both benefits is necessary that takes into account the breadth of offerings currently available to K-12 public school employees and the degree to which the current offerings involve self-insured and fully-insured products. The Health Care Authority does not have sufficient capacity to complete these designs and to complete a competitive procurement for the 2013-14 school year in light of other competing demands for 2014.
2. The existing Health Care Authority infrastructure that serves the PEBB program does not have capacity to absorb this level of expanded enrollment given the complexities associated with life and long-term disability benefits. The risks posed to the current infrastructure constitute an unacceptable threat to the PEBB program and to the successful initial implementation of the consolidated K-12 employees' health benefits purchasing system.

Another aspect of providing covered benefits has to do with requirements for the purchase of each covered benefit through the consolidated K-12 employees' benefits purchasing system. Three aspects of this topic are discussed below.

PURCHASE OF MEDICAL/RX BENEFITS

The content of written materials generated during the 2010 legislative general session and special session and subsequent discussions with all parties participating in this project clearly set the medical benefit as the primary focus in the consolidated employees' benefit purchasing system design. As such, the Health Care Authority proposed design is built on the following underlying assumption about the intent of the legislature in directing the Health Care Authority to propose a design for a consolidated K-12 public school employees' benefits purchasing system:

All school districts and educational service districts required by statute to participate in the consolidated K-12 public school employees' benefits purchasing system will cover the medical benefit for their

employees and must purchase the medical benefit exclusively through the consolidated purchasing system. This does not impact the ability of the employee to waive the medical benefit coverage.

This underlying assumption by the Health Care Authority is made with acknowledgement that a conflict will be created with subsection (3) of 28A.400.270 RCW that currently allows for the coverage decision of all five basic benefits to be determined through local collective bargaining.

PURCHASE OF OTHER BENEFITS

After the medical benefit, the dental benefit is the benefit most offered by districts among the five basic benefits. Data collected from school districts indicates that the vast majority of public school employees who are offered dental benefits currently receive them through fully-insured benefit plans, with the premium paid almost exclusively through the employer contribution. The WEA-Premera Dental Plan A is selected by the large majority of eligible employees. Very few districts have self-insured dental plans currently. Premiums for the vision, life and long-term disability benefits are funded through a 100% employer premium contribution.

In modeling the financial environment under a consolidated K-12 public school employees' benefits purchasing system, the current employer premium contribution shares for dental, vision, life, and long-term disability benefits are maintained. Assuming districts required to participate in the consolidated employees' benefits purchasing system do have to purchase medical benefits as described above, a second assumption follows that these same districts that provide any of the other five benefits to employees will purchase those benefits through the consolidated employees' benefits purchasing system at the point they are made available by the consolidated employees' benefits purchasing system.

For the period during which life and long-term disability benefits are not available through the consolidated public school employees' benefits purchasing system, the employer premium contributions to those benefits must be accounted for in setting employer premium contributions for benefits in the consolidated public school employees' benefits purchasing system.

TYPES, NUMBERS AND RELATIVE VALUE RANGE OF BENEFITS PLANS

The medical benefit plan portfolio will contain at a minimum, one statewide preferred provider organization (PPO) plan. At least one health maintenance organization (HMO) plan will also be offered in geographical areas of the State where a qualified, affordable plan is available. During the development of the request for proposal to secure health plan carriers, additional types of plans and variations on traditional PPO and HMO plans may be included, including a consumer directed health plan. The exact makeup of the portfolio will be determined during the carrier selection process.

The Health Care Authority was not able to determine with an acceptable degree of accuracy the total number of medical plans currently available to public school employees. Data provided to the Health Care Authority by districts and medical plan carriers identifies some of the major plans offered by individual carriers but not all. In cases where the carrier chose not to provide information directly, the

Health Care Authority had to rely on information from the school districts that contained a high level of inconsistency in how plans were identified. Discussions with multiple district officials verified that some of the major carriers do provide customized plans on an individual district basis.

The relative value range of the current K-12 employee medical benefits plan portfolios of the major carriers will be used as the boundaries within which the consolidated employees' benefits purchasing system medical benefit portfolio will be designed. As noted elsewhere in this section, a benchmark plan will be established and from that plan other plans designs will be added with both higher relative values and lesser relative values to achieve an overall relative value range approximating that of the current K-12 employee medical benefits plan portfolio.

To enable the Health Care Authority to effectively administer a consolidated K-12 employees' benefits purchasing system an initial target has been set to develop a medical plan portfolio containing approximately 10 PPO plan options and 3 HMO plan options. As work proceeds in preparation for implementation in 2013-14, the portfolio size will be set by the consolidated purchasing system governing board to achieve access to affordable plans across a large portion of the spectrum of income levels within the K-12 public school system and a menu of plan type and carrier choices when possible.

BENCHMARK PLAN

NOTE: This section discusses high level features of the proposed health benefits plan portfolio for the consolidated K-12 public school employees' benefits purchasing system. For a detailed description of the Financial Modeling summarized below, readers should refer to report Volume three – Financial Modeling Regarding the Health Care Authority Consolidation of Health Insurance Benefits for the Washington K-12 School Districts.

While developing the project scope to establish a realistic workload that would enable the Health Care Authority to successfully address the most important aspects of the legislative directive within the allotted time, the decision was made to provide a benefit plan portfolio model rather than to attempt to design a proposed portfolio that delineated the details of a specific number of benefit plans for medical, dental, and vision benefits. This decision was based on the fact that the proposed design for a consolidated K-12 public school employees' benefits purchasing system presented by the Health Care Authority will in all likelihood be subsequently modified before taking a final form. Providing a portfolio model with sufficient specificity, while allowing flexibility for some level of modification, was determined to be the proper balance to assure successful outcomes for the project, recognizing that a greater level of detail was expected by some who will scrutinize the report.

Because the medical benefit receives the most attention, modeling focused on developing the medical benefit portfolio model from which a dental portfolio model and other benefit portfolio models could be replicated as appropriate. The selected approach to developing the model involves the use of a benchmark comprehensive plan using the features of a currently functioning K-12 employee benefits plan. The array of current benefit plans was analyzed by Milliman Inc. to find a plan that is selected

by a large number of employees, is a preferred provider organization (PPO) plan, and has a relative value higher than the Uniform Medical plan, but maintained budget neutrality in the K-12 consolidated modeling. The WEA-Premera Plan 2 was selected to be the benchmark plan for initial modeling.

A goal was set for the modeling to establish a consolidated employees' benefits purchasing system benchmark plan that achieves cost-neutrality when measured against current **public funds** expenditures by all districts in the K-12 public school system.

It is important to note that the current K-12 employee medical benefit plans are for the most part fully-insured and the contracted medical plan carriers possess the detailed cost information associated with the makeup of their premiums and the claims experience of their K-12 employee covered lives. The Health Care Authority was unable to access information about several cost centers either from the districts or the contracted medical insurance carriers for the fully-insured medical plans to enable Milliman to model cost-neutrality below the total expenditure level. In some cases health plan administrators in the K-12 employees' benefits array reported that they did not have access to cost center data below the premium level or claims experience data for their specific covered lives, even at the aggregate level. As public purchasers and as stewards of public funds received from the state, federal government, and local taxpayers, they perceived the lack of access to detailed data related to health benefits administrative costs, expenditures for care, and employee benefit utilization patterns to be a serious limitation.

The following assumptions were made to guide modeling to establish the benchmark plan:

1. WEA-Premera Plan 2 is used as the baseline plan for the calculation of the employer financial contributions for medical benefits.
2. The employer will contribute a fixed percentage of the premiums for employees and a separate fixed percentage for dependents. An acceptable range for the employer contribution for the employee-only tier fixed percentage is 75% - 90%.
3. For the Employee/Spouse, Employee/Child(ren), and Employee/Family tiers, the dependent percentage contribution is applied to the marginal portion of the premium, e.g. the total premium less the employee-only tier contribution for the same plan. An acceptable range for the employer marginal contribution fixed percentage is 50% - 75%.
4. The existing proration methodology used in the K-12 employee health benefits array is retained.
5. All employees currently participating in medical benefit programs will continue to be served.
6. Migration will happen between plans and between tiers and this is accounted for in the modeling.

RECOMMENDATIONS

A. The consolidated employees' health benefits program will initially purchase the following basic benefits on behalf of employing agencies:

   1. Medical and pharmacy.
   2. Dental.
   3. Vision.

B. Life & LTD benefits will not be purchased by the consolidated benefits program for the initial benefit year.

C. A participating district must purchase medical/Rx and dental benefits through the consolidated benefits purchasing system.

   The district must purchase medical Rx in order to purchase any other insurance benefit available through the consolidated benefits purchasing system.

   Until such time as the governing board authorizes purchase of an insurance benefit, districts are responsible for the provision of covered benefits directly or through contract with other insurance carriers.

D. Initially the consolidated benefits program benchmark medical/Rx PPO plan relative value will closely approximate the relative value of the 2011 WEA-Premera Plan 2. All other PPO and HMO relative plan values will be determined in comparison to this benchmark plan.

   Thereafter, the purchasing system board will establish the benchmark plan's relative value and the relative values of all offerings within the portfolio.

E. Initially the consolidated benefits program portfolio relative value range will be designed to achieve the approximate range that exists in the current K-12 portfolio while reducing the medical/Rx portfolio to approximately 10 PPO plans and 3 HMO plan.

   Initially the consolidated system portfolio will include a consumer-directed health plan with an associated health savings account or health reimbursement account and other value-based plan designs will be added as the system matures. The board will coordinate with the Public Employees Benefits Board to develop benefit plans that rely on consistent evidence-based medicine policy, high performing provider networks, and other accountable care models.

   Thereafter, the purchasing system board will establish the portfolio relative value range and individual relative value of offered plans.

IMPACTS TO CURRENT K-12 PUBLIC SCHOOL SYSTEM

The underlying assumption by the Health Care Authority that all participating districts must cover the medical basic benefit conflicts with subsection (3) of 28A.400.270 RCW that currently allows for the coverage decision of all five basic benefits to be determined through local collective bargaining.

Districts that cover the life and long-term disability basic benefits will have to maintain a separate employee benefits purchasing program for the life benefit and long-term disability benefit, and incur the associated costs, until these benefits are available through the consolidated purchasing system.

Benefit carriers that are not selected for the consolidated purchasing system will lose the public school employee client share of their book of business.

Consultants and contractors who currently receive fees and commissions from school districts and benefit plan carriers for broker services will lose some portion of their revenue as a result of benefits purchasing responsibilities moving to the Health Care Authority.

REQUIRED STATUTORY CHANGES

A. See section B – Governance Structure statutory changes.

B. 28A.400.270(3) RCW will have to be amended to require school districts participating in the consolidated purchasing system to cover medical benefits.

5. REVENUE SOURCES AND COST SHARING RESPONSIBILITIES

OVERVIEW

In developing the proposal for a consolidated K-12 public school employees' benefits purchasing system, the Health Care Authority considered three primary aspects of benefits financing:

1. Revenue sources.
2. Premium structure.
3. Point of service cost obligation.

Following the selected design approach based on a benchmark plan, the project design team established financing design policies for each of the three aspects. Milliman followed these policies in modeling a variety of combinations of employer and employee cost-sharing to arrive at a combination that presented positive contributions to advancing the goals set out for the consolidated purchasing system proposal by the legislature.

The combination chosen by the Health Care Authority was only one of multiple viable combinations that were modeled. In evaluating the viable options, two factors were kept at the forefront:

1. Achieving meaningful improvement in access to affordable benefits insurance for all employees by eliminating major differences in out-of-pocket premium expenses for employees who do and do not need coverage for dependents.
2. Designing a benefits plan portfolio and premium rate structure that is consistent with other large employer employees' benefits designs in Washington and other public school employee's benefits designs across the nation.

To develop an understanding of the existing K-12 cost-sharing arrangements, data was collected from districts and contracted insurance plan carriers and analyzed by Milliman. The results of the data analysis are contained in report Volume three, Financial Modeling.

REVENUE SOURCES

The State's participation as a revenue source for K-12 public school employee's benefits creates a shared funding arrangement with the local districts contributing local levy monies and employees' out-of-pocket contributions being the other major revenue sources. Other smaller revenue sources include the federal government and grants. For purposes of this report funds received by districts from the State, federal government, local levies, grants, and other non-employee sources are characterized as the ***employer contribution*** and no attempt is made to report the breakout of these funds in the report.

For the 2010-2011 school year, expenditures for K-12 public school employees' health benefits were approximately $1.3 billion dollars of which 82% was paid through employer contributions and 18% was paid through employee contributions. Expenditures for medical benefits comprised $1.09 billion with 78% paid through employer contributions and 22% paid through employee contributions. For dental, vision, life, and long-term disability insurance, on average the employer contributes 99% to 100% of the premium amount.

In keeping with current funding arrangements, the proposed consolidated K-12 public school employees' benefits purchasing system is structured around a continued shared responsibility. Each year the Health Care Authority will prepare a budget projection, including annual inflationary figures as consistent as possible in comparison with the PEBB program and other state plans (Medicaid and L&I,) sufficient to cover the anticipated costs of the consolidated purchasing system. This projection will include a breakout of a projected State share computed from prior funding level experience specific to the consolidated purchasing system. The budget projection will be reported to the Governor's Office. Ultimately a state allocation for health benefits will be determined by the Legislature and allocated through the State budgeting process for the K-12 districts, as is the current practice.

PREMIUM STRUCTURE

NOTE: This section discusses high level features of the proposed premium structure for the consolidated K-12 public school employees' benefits purchasing system. For a detailed description of the Financial Modeling summarized below, readers should refer to report Volume three – Financial Modeling Regarding the Health Care Authority Consolidation of Health Insurance Benefits for the Washington K-12 School Districts.

The proposed K-12 consolidated purchasing system relies on a premium structure that requires both the employer and the employee to make a contribution to the premium cost. Similar to the existing K-12 benefit programs, the employer under the consolidated purchasing system contributes the vast majority of the premium for non-medical benefits and the employer and employee have a more balanced cost-share obligation for the medical benefit.

One key finding of the existing K-12 employees' benefits array data analysis relates to the average employee premium contribution paid in the 2010-11 school year. In that year, full-time employees contributed an average of 4% for employee only coverage while employees covering dependents contributed on average 73% of the increased premium amount associated with the addition of dependents. This incongruent level of required contribution to the premium amount associated with dependent coverage is in large part the basis for legislative concern about inequitable access to affordable health benefits between employees who do and do not cover dependents through their K-12 employees' benefits program.

In order to address this degree of disparate premium contribution, two design policies were established to guide the financial modeling for a consolidated purchasing system:

1. Employer premium cost share for employee-only tier: **The employer premium contribution for the employee-only tier will be set within a range of 75% to 90% of the total premium for the benchmark medical plan.**
2. Dependent premium cost share: **The employer premium cost share for the dependent tiers will be composed of (a) the employer premium contribution for the employee-only tier plus (b) an additional amount within the range of 50% to 75% of the remaining balance of the total premium for the dependent tier.**

Two other important premium-related aspects of current K-12 employees' benefits design that were considered in establishing design policy for the consolidated K-12 benefits purchasing system involved pro-rating of the employer contribution and enhanced employer contributions. In the current K-12 employees' benefits array, the predominant practice is to allocate the employer contribution to premium based on an employee's defined work status in relation to a full-time equivalent (1.0 FTE). A full-time employee receives a full employer premium allocation. Part-time employees receive reduced allocation that is proportional to his or her FTE status. The consolidated K-12 purchasing system design incorporates the pro-rating practice and applies a standard pro-ration formula for all districts and all employees.

One significant modification contained in the consolidated purchasing system design specifically prohibits districts from providing additional monies to the employer premium contribution beyond the level specified in the published consolidated purchasing system rate schedules for each benefit year. Currently, through district policy and collective bargaining agreements, the employer contribution can be established at the individual bargaining unit level independent of employer contribution amounts negotiated by other bargaining units. This variation can occur between employee groups and between bargaining units with the same employee group. The ability to do this is based in state law. The situation becomes even more complex due to the number of factors involved in determining how much money the district has available to negotiate enhanced employer premium contributions. These factors include the district's local levy capacity, the amount of local levy amounts as approved by voters, the number of employees in the bargaining unit that are not eligible for the covered benefits, and the number of employees in the bargaining unit that waive coverage. Adjustments to the employer contribution may happen more than once during a benefit year. The inequities that result between employees within a district and between districts are one concern the legislature directed the Health Care Authority to address.

Under the fixed premium contribution percentage methodology described above for the consolidated purchasing system, when an employee chooses a plan other than the benchmark plan, the employee incurs the full cost associated with selecting a more expensive plan (richer benefit package) and gets the entire savings for making a less expensive choice, subject to minimum contribution requirements .

POINT OF SERVICE COST OBLIGATION

Another significant modification built into the consolidated purchasing system design moves the responsibility for benefit plan design from the individual districts to the K-12 consolidated benefits purchasing system governance structure. Employee point of service cost share obligations, including deductibles, co-insurance/co-payment, and out-of-pocket maximums, are integral components of the benefit plan design. Under the consolidated purchasing system arrangement, the district and its employee bargaining units will no longer have the authority to define employee point of service cost-sharing levels at an individual district level; the cost-sharing levels will be set uniformly by benefit plan for all employees selecting the plan.

PREMIUM PAYMENT RESPONSIBILITY

One other feature of the consolidated purchasing system design worth discussing has to do with premium payment responsibility. As the employing agency, the district will retain the responsibility to collect premium contributions from employees and to submit payments directly to the insurance carriers for the full premium amount established in the consolidated purchasing system rate schedules. The district will also be responsible to provide the Health Care Authority documentation of premium payments in accordance with established reporting requirements for the consolidated purchasing system.

2010 MERCER NATIONAL EMPLOYER SURVEY

For general comparison purposes, the Health Care Authority researched national statistics relating to public school employees' benefits program designs. Once source document received from Mercer (Appendix D) contains a subset of the 2010 Mercer National Survey of Employer-Sponsored Health Plans specific to school districts. That document supports the directional change of our employee contribution requirements. While the study is limited to a sample of only 117 school districts, it shows a 23% contribution requirement of employee-only PPO coverage and 41% for family PPO coverage for those districts that require employees to contribute.

RECOMMENDATIONS

A. The Health Care Authority will provide the Governor's office an annual budget projection, including annual inflationary figures as consistent as possible in comparison with the PEBB program and other state plans (Medicaid and L&I), for the consolidated purchasing system sufficient for the cost-effective provision of employee health benefits.

B. Health plan premium rate schedules will be established in accordance with a uniform methodology for pro-ration of employer contribution based on FTE status from 1.0 FTE through 0.5 FTE. The established rate schedules will be in effect for the full benefit year.

Individuals in an employment status less than 0.5 FTE under an initial 5-year grandfathering arrangement will participate at the 0.5 FTE level.

C. Employing agencies will collect premium contributions from participating employees and submit payments directly to the insurance carriers for the full premium amount established by consolidated purchasing system rate schedules. Each district will provide the Health Care Authority reporting of premium payments in accordance with established consolidated program reporting requirements.

D. The employer premium contribution for the employee-only tier for the consolidated purchasing system will be initially set at 85% of the total premium for a benchmark medical plan comparable to the existing WEA-Premera Plan 2. The consolidated purchasing system board will establish the premium contribution for the benchmark plan thereafter.

E. The employer premium contribution for dependent coverage in the consolidated purchasing system will be initially set using a marginal contribution of 65% for a benchmark medical plan comparable to the existing WEA-Premera Plan 2. The consolidated purchasing system board will establish the marginal dependent premium contribution for the benchmark plan thereafter in a manner that supports equitable access to health benefits for employees covering dependents.

F. Employee point of service contribution levels will be set by the consolidated purchasing system governing board through the initial portfolio design and procurement process. The purchasing system board will establish the point of service contribution levels for the benefits plan portfolio thereafter.

G. In order to avoid subsequent migration to inequitable premium cost sharing between employee bargaining units, employee groups, or individual districts, districts may not enhance the employer contribution to the premiums established by the governing board thereby reducing the established employee contribution to the premium.

H. When an employee chooses a plan other than the benchmark plan, the employee incurs the full cost associated with selecting a more expensive plan (richer benefit package) and gets the entire savings for making a less expensive choice, subject to minimum contribution requirements.

IMPACTS TO CURRENT K-12 PUBLIC SCHOOL SYSTEM

The features of the consolidated purchasing system design related to financing constitute a substantial impact to current practice for districts, employees, and local collective bargaining arrangements. The decision-making authority and responsibilities of local districts, employee groups and employee bargaining units will be transferred to the governing board of the consolidated benefits purchasing system in the following areas:

1. Determination of employer premium contribution levels for employee-only coverage and for employee plus dependent coverage,
2. Determination of employee point-of-service cost obligation levels through plan benefit design.

3. Use of employer contribution pro-rating arrangements and formulas based on FTE status.
4. Provisions for coordination of benefits.

In addition, a prohibition on additional employer contributions beyond the established rate schedules is imposed.

REQUIRED STATUTORY CHANGES

A. See section B – Governance Structure statutory changes.

B. 28A.400 RCW will have to be amended to address modifications to text related to school district pooling state benefit allocations to be consistent with the consolidated purchasing system design described in this section.

6. PARTICIPATION REQUIREMENTS

OVERVIEW

Operating as separate benefits purchasing entities, the 300 plus districts face insurmountable challenges to achieving a statewide integration of effort that can keep pace and aligned with the dynamic Washington health care market. Even with the successes of individual districts and insurance sponsors and carriers to improve employees' health benefit, these individual efforts are at best slowly filtering into the broader array of employees' benefits programs.

In developing the authorizing language for this project, the Legislature recognized the potential a consolidated purchasing program provides for driving system wide improvements in the K-12 employee health benefits array. Decisions relating to required participation by school districts and educational service districts in a consolidated public school employees purchasing system will significantly impact the degree to which **system wide** improvements are achieved and the K-12 employees' benefits reflect reform initiatives occurring in the Washington health care market. In addition, participation decisions will impact the complexity and workload involved in administering the purchasing system. Following is a discussion of differing degrees of system wide participation by districts.

Three aspects of participation in a consolidated employees' benefits purchasing system are of prime importance in relation to the school districts and educational service districts, and to their employee bargaining units. The first is the basic requirement for participation, in which the range of options spans from all-voluntary to all-mandatory. The second involves parameters that would apply in the case where participation in the consolidated purchasing system is the preferred arrangement, but provisions exist for voluntary non-participation. The third is associated with voluntary non-participation and relates to the entity authorized to request an exception to mandatory participation.

Intertwined in each of the above three aspects are varying levels of impact to system wide improvements to:

1. Equitable access to benefits by all employees.
2. Transparency.
3. Cost-effectiveness to the state, districts, and employees, associated with the level of employee participation achieved across the statewide K-12 public school system.

An assessment of the three aspects was conducted to allow the evaluation process to build upon itself as foundational assumptions and decisions were made. In addition, these options were considered within the scope of a K-12 community rated risk pool separate from the state employees' risk pool, as recommended earlier. When important to the discussion, features of the PEBB program are described to provide clarity about the current arrangement between the K-12 employees' benefits array and the PEBB program. Information obtained through case studies of other states was also considered; this information is included in the full case studies elsewhere in this report.

BASIC REQUIREMENT FOR PARTICIPATION

The consolidated benefits purchasing system potentially could be established as an optional source of employee benefits for districts under a voluntary participation arrangement, as the sole source of employee benefits for all districts under a mandatory all-in arrangement, or as a mandatory arrangement with provisions for voluntary non-participation. In evaluating these options, two assumptions were made:

1. An exception to participation in a mandatory consolidated public school employees' benefits purchasing system includes terms that must be met to qualify for the exception.
2. All districts eligible to participate in the consolidated public school employees' benefits purchasing system that receive state funds for employee benefits are required to comply with reporting requirements in accordance with state law and rules applicable to the consolidated public school employees' benefits purchasing system. Districts that receive an exception to mandatory participation must incorporate applicable reporting requirements into all contracts with benefits providers as a term of the exception.

FULL VOLUNTARY PARTICIPATION

Currently, school districts and educational service districts can apply to participate in the Public Employees' Benefits Board program on a voluntary basis. Fifty of 295 school districts and four of nine educational service districts have contracts in place in 2011 to receive services for one or more employee groups of the district. There are approximately 4,000 enrolled members from predominantly small districts. Establishing a separate public school employee benefits purchasing system may overcome some of the PEBB program fiscal issues that result in low participation, but the fundamental outcomes associated with an unrestricted voluntary approach will continue.

In considering this arrangement, careful consideration must be given to:

1. The stability of the consolidated benefits purchasing system.
2. The capacity of individual districts to assess the competitiveness of their available options on a regular basis.
3. The capacity of the Health Care Authority to develop and maintain infrastructures and administrative processes to accommodate the complexities and workload intensity of annual fluctuations in the number of districts involved.
4. The impact on the equitable access to benefits by all employees, transparency, and cost-effectiveness to the state, districts, and employees.

The ability of districts to move in and out of the consolidated benefits purchasing system creates ongoing risk to the stability of the system due to:

1. The potential effects of adverse selection detrimental to the consolidated system risk pool.
2. The effects of low participation on the funding pool.

It also substantially increases the resource needs of the Health Care Authority to enable an acceptable level of responsiveness to the volume of annual enrollment and disenrollment activities associated with employing agency application and contracting.

The consolidated purchasing system is intended to instill a greater level of consistency and stability in employee benefits design on a statewide basis to overcome the complexity and variation created in an environment of 300 plus distinct benefit programs. In a voluntary arrangement, there is no impetus to create or maintain consistency and stability of design beyond the individual district level. As a result:

1. The State, districts and employees are subject to swings in premium rates from year to year as insurance carriers annually vie for the business of individual districts.
2. Local collective bargaining drives unique arrangements that pose a risk for continued or exacerbated inequities within and between the non-participating benefit programs.
3. Data inconsistency and transparency issues remain.

MANDATORY PARTICIPATION WITH AN EXCEPTION FOR ONGOING VOLUNTARY NON-PARTICIPATION

In this arrangement, participation is mandatory but an exception is provided to enable a district to obtain employee health benefits through contracts with other entities upon approval of the Health Care Authority. Approval would be contingent on the district demonstrating compliance with the terms for exception.

The potential impacts of this arrangement are similar to those of a fully voluntary arrangement with the degree of impact determined by the terms imposed for the exception. The more restrictive the terms are set, the fewer districts will be inclined to make application for an exception and the number of applicants demonstrating compliance may be reduced. As the number of successful exceptions decreases the impacts to statewide consistency and to the consolidated purchasing system will also decrease. Any level of non-participation increases the potential that inequities will continue and could be exacerbated and transparency of the overall K-12 public school system will be diminished.

Because this arrangement provides for ongoing opportunity to successfully receive an exception, and to then subsequently apply for participation in the consolidated program, an enhanced workload is imposed on the consolidated purchasing system to process applications on an ongoing basis for both those districts desiring to not participate and those desiring to participate at a subsequent date.

MANDATORY PARTICIPATION WITH AN EXCEPTION FOR ONE-TIME VOLUNTARY NON-PARTICIPATION

Limiting the opportunity to receive an exception to participation further reduces the impacts to the system. In this case, the opportunity is limited to initial participation in the consolidated purchasing system. Once a district has participated in the consolidated purchasing system, continued participation becomes mandatory from that point forward. A district seeking exception from initial participation

must demonstrate compliance with the terms of the exception at the time of application and ongoing in accordance with a defined time interval (e.g. 2-3 years).

Impacts related to the risk pool and funding pool become negligible in this approach if the terms of the exception are sufficiently restrictive so detrimental adverse selection is not encouraged. For those districts that do receive an exception and maintain it over time, the risks remain that they will diverge from the consistency and equality achieved among participating districts.

Initially, there will be an enhanced workload imposed on the consolidated purchasing system to process applications. Ongoing there will be a lower level of workload associated with review of renewal applications for those districts wishing to continue the exception and with processing applications for those requesting to participate in the consolidated benefits purchasing system.

FULL MANDATORY PARTICIPATION

Mandatory participation by all school districts and educational service districts achieves the greatest degree of consolidation into a complete statewide purchasing system for school employee health benefits. Full participation drives the highest degree of uniform purchasing policy, access to the same benefit designs, cost-sharing arrangements, and eligibility parameters by all employees, and transparency of the true costs and other information needed by employers and benefit purchasing agents to make sound decisions.

As a consolidated purchasing system, mandatory participation affords enhanced stability for the risk pool and funding pool and reduces the infrastructure complexities and workload requirements associated with participation exceptions.

At the same time, mandatory participation imposes a level of consistency and uniformity that does not take into account the current level of performance of individual district employee benefits programs. The potential exists for individual programs to achieve levels of improvement in areas of importance to state policy makers that exceed levels achievable by a consolidated purchasing system. In that case, mandatory participation poses some level of loss for employees. Full mandatory participation places a high expectation on the State to manage the consolidated employees' benefits purchasing system at a level of performance that assures districts and employees do not lose access, quality, or affordability in the health benefits as a result of factors not otherwise based on sound purchasing strategy and policy.

VOLUNTARY NON-PARTICIPATION EXCEPTION WITH TERMS

In evaluating the option to allow voluntary non-participation in an otherwise mandatory purchasing system, discussions continually turned to the nature of terms under which an exception would be granted. The project design team pursued two avenues of information to inform their discussions;

1. Two of the three states chosen as case studies for this project have exceptions to mandatory requirements for school district participation in their existing state-sponsored consolidated

employees' benefits purchasing systems for public school employees: Oregon and Texas. In conducting the case studies, project staff included interview questions specific to the topic of exceptions for voluntary non-participation. The information gained is reported in the case studies contained in this report.

2. A project work group composed of representatives of the project design team and advisory team was formed to brainstorm options that could be used to set the terms for a voluntary non-participation exception. Summaries of those meetings were made available for review by other persons on the project design team and advisory team, as well as other interested persons.

As a result of these efforts and subsequent discussions with other project participants, six criteria were selected to form the basis upon which an exception to mandatory participation could be granted; three based on characteristics of the district and/or its employees' benefits program and three based on comparability to the consolidated employees' benefits purchasing system design. Any of the six, or a variety of combinations of the six, could constitute the exception terms.

NUMBER OF DISTRICT EMPLOYEES

A threshold number of district employees is set as a baseline qualification. The rationale for selecting the threshold level should be based on resolving an issue or achieving a goal that is predominant in the school districts that fall below the threshold.

For example, Texas imposed mandatory participation for school districts with fewer than 500 employees but allowed voluntary participation by districts with 500 or more employees. The Texas Legislature determined the most pressing issues were in smaller districts with 500 or fewer employees. School administrators in these districts found it difficult to find affordable coverage and sometimes could not find carriers at all.

SIZE OF EMPLOYEE RISK POOL

A threshold risk pool size is set as a baseline qualification. The rationale for selecting the threshold level should be based on research or other objective information that demonstrates a risk pool can be managed in a stable state with as few covered lives as the set threshold.

If this criteria is used, accompanying decisions must be made whether to: a) allow districts to enter into formal interagency agreements to form a consolidated purchasing program that meets the risk pool threshold and/or b) allow employee unions to receive an exception based on meeting the risk pool threshold through participation in health benefits sponsored by their affiliated national organization.

SELF-INSURED BENEFITS PROGRAM OR BENEFITS TRUST

Districts that self-insure a covered benefit or utilize a benefit trust as the purchasing system could be eligible for an exception. The rationale for this approach is based on the assumption that these two arrangements involve an increased level of benefit program management as a result of the increased

district responsibility for the financial risk of a self-insured plan or the formal oversight of a board of trustees for a benefit trust.

For example, in establishing the Oregon Educators Benefits Board purchasing system, the Oregon Legislature incorporated a one-time opportunity for exception to mandatory participation (with terms) for districts that were self-insured or had an established independent health insurance trust at the time the authorizing statute became law. The exception remains in effect until such time as the district chooses to participate in the Oregon Educators Benefits Board purchasing system. At that point the district must continue to participate without opportunity for a subsequent exception.

During this project a sample of districts with self-insured medical/Rx benefit plans and districts with benefit trusts were interviewed. In all cases, the districts had moved in the direction of consolidation envisioned for a statewide consolidated benefits purchasing system in order to unify primary decisions, including benefit program eligibility, benefit design, employer/employee cost-sharing, and benefit plan carrier selection. These decisions were moved to a policy committee level to achieve equal access to health benefits for all employees.

PREMIUM COMPARABILITY

In this case, premiums for the benefit plans provided or contracted for by the district are equal to or less than the premiums for comparable benefit plans provided by the consolidated employees' benefits purchasing system. The rationale for selecting premium comparability is solely assuring cost-effectiveness of those districts not participating in the consolidated purchasing system. This minimal criteria may entice employee groups, consultant and contract brokers, contracted benefits plan carriers, and others who face a loss of rights, revenue, or autonomy, etc., to consider applying for an exception to mandatory participation in order to escape those impacts. Careful consideration should be given to the threshold number of non-participating districts and employees that would constitute an unacceptable loss of equitable access to health care benefits and transparency of employee health benefits costs across the statewide K-12 public school system.

The Oregon Legislature used premium comparability as a term of qualification in the Oregon Educators Benefits Board purchasing system, but tied it to a more restrictive criteria based on the requirement that districts must be self-insured or an independent benefit trust.

Premium comparability provides a simple qualification to administer that provides an assurance of comparable affordability overall, and for the state, but it does not address employer/employee premium sharing arrangements and therefore retains the potential for inequities between employees within a district and between districts. Premium comparability does not provide assurance of adequate provider access.

PREMIUM COMPARABILITY AND ADEQUATE PROVIDER ACCESS

This set of criteria expands the qualification standard for exception beyond premium comparability,

as described above, to include assurance that benefit plans utilized under an exception provide documentation that demonstrates adequate network access and capacity to serve the district population.

For example, during the 2010 competitive procurement for a Uniform Medical Plan third party administrator, the Health Care Authority required bids from health plan carriers to provide information on the number of contracted network providers within a designated radius of the center of each zip code area in Washington. The results were compared to provider access standards established by the Office of the Insurance Commissioner for specific provider types and also to the existing provider network of the Uniform Medical Plan. A similar access analysis could be required for the zip codes encompassing the specific school district or educational service district and compared to the Office of the Insurance Commissioner standards and, as appropriate, the benchmark plan for the consolidated public school employees' benefits purchasing system.

FULL COMPARABILITY

To ensure the most comprehensive system wide improvements in cost-effectiveness, equitable access to health benefits by all employees, and performance transparency, multiple criteria would be necessary to document full comparability between those districts that participate and those granted an exception to participation in the consolidated public school employees' benefits purchasing system.

The complex set of criteria necessary to assess full comparability would involve substantive expense for the districts in preparing applications for exception. The work and expense for the Health Care Authority to accurately assess comparability on all aspects would be significant. More than any of the other options discussed, full comparability will dictate the Health Care Authority establish the critical mass of participating districts necessary to absorb the costs associated with processing applications without jeopardizing the cost effectiveness of a consolidated employees' benefits purchasing system.

ENTITY AUTHORIZED TO REQUEST EXCEPTION TO MANDATORY PARTICIPATION

In addition to school districts and educational school districts, existing rule 182-12-11 WAC authorizes employer groups to participate in Public Employees' Benefits Board insurance coverage at the option of each employer group. In addition, bargaining units and non-represented employees as a unit may elect to participate separate from the whole employee group.

In determining the entities that are authorized to make application for an exception to mandatory participation in a separate K-12 consolidated public school employees' benefits purchasing system, consideration must be given to whether an entity within a district will be eligible to receive an exception. If the ability to request and receive an exception at a level below the full district is authorized, consideration should be given to the makeup of the authorized entity. Two versions of possible employee group makeup in addition to the full district are presented below for discussion.

LOCAL BARGAINING UNITS

The HayGroup® estimated there were as many as 1,200 funding pools associated with individual local bargaining units within the K-12 public school system in 2010. This number of bargaining units is arguably one major factor contributing to the complexity of the current K-12 employees' benefits array and the wide variation in benefit access and affordability for employees. Introducing non-participation into a mandatory consolidated public school employees' benefits purchasing system at this sublevel within the school districts will impose a high degree of complexity and pose substantial risks to the cost-effectiveness of the consolidated purchasing system. In addition, the potential for exacerbated inequities between bargaining units and employee groups is assured.

EMPLOYER GROUPS

Restricting authority to request an exception to whole employee groups significantly reduces the complexity and the potential risk of wide variation in benefit access and affordability for employees. It maintains a level of autonomy between employee groups and retains a level of decision-making below the full district level, albeit much less than exists among over 2,000 individual bargaining units at the current time. Moving to this sublevel within the district will create a lower level of complexity but will still come with credible risks to the success of the consolidated system in advancing the goals of Legislature.

FULL DISTRICT

Limiting the option for voluntary non-participation to the full district level clearly establishes the intent of the Legislature to develop a greater level of alignment across the K-12 public school system of employee benefit programs in regards to common purchasing policy, equitable health benefits for all employees regardless of employee group or provision of coverage for dependents, and performance transparency. In this case, a district seeking an exception must coordinate with its employee groups and bargaining units to develop a district-wide health benefits governance and operations structure to assure the non-participation qualifications are met and all district employees share equally in the advantages and disadvantages resulting from non-participation.

From a consolidated employees' benefits purchasing perspective, restricting the option to a full district level simplifies the administration of the non-participation application and review process.

RECOMMENDATION

All covered employing agencies are required to participate in the K-12 public school employees' benefits purchasing system.

ALTERNATE APPROACH

If the legislature authorizes by statute a provision for voluntary non-participation the statute should specify terms for an exception to mandatory participation that include:

1. An exception to mandatory participation may be granted by the Health Care Authority at any time upon completion of an application process that includes documentation that the applicant complies with specified terms of the exception.
    a. At a minimum, the terms of exception will require demonstration of premium comparability and adequate provider access.
    b. After the initial implementation of the consolidated employees' benefits purchasing system, the terms of exception will include a required minimum time span for consolidated purchasing system participation and non-participation prior to requesting a change in participation status to assure the stability of the consolidated purchasing system risk pool.
    c. The terms of exception will require re-application to demonstrate ongoing compliance with other terms of the exception. The cycle for re-application will correspond to the time span established for item b.
    d. A request for exception to mandatory participation may only be filed by a school district or educational service district and must demonstrate compliance with the terms of exception for all employees of the district.
2. The consolidated purchasing system governing board will have the responsibility to approve or disapprove exceptions to mandatory participation in accordance with established terms and conditions and to establish penalties to be imposed when the employing agency fails to comply with established participation criteria.
3. The Health Care Authority shall ensure the continued integrity of the consolidated K-12 public school employees' benefits purchasing system and shall limit the number of exceptions granted to new applicants if the number of participating districts is approaching a level where there will be insufficient participation to offset the administrative costs of the consolidated purchasing system.

IMPACTS TO CURRENT K-12 PUBLIC SCHOOL SYSTEM

Because this section deals with the requirements for participation in an established consolidated public school employees' benefits purchasing system, the impacts to districts, employees, and employee bargaining units are outlined throughout this section as the impacts associated with the transition to a consolidated purchasing system. As described in the above narrative, the decisions by the Legislature regarding the level of mandatory participation will dictate the impacts to the districts that do and do not participate in the consolidated purchasing system.

REQUIRED STATUTORY CHANGES

Provisions will need to be added to 41.05 RCW describing the participation requirements for the consolidated public school employees' benefits purchasing system. If participation is mandatory, the RCW will have to address the degree to which voluntary non-participation is authorized and any associated terms and conditions to quality for an exception to mandatory participation.

ADMINISTRATIVE SAVINGS

BACKGROUND

The 2010 HayGroup® report projected a set of potential cost savings resulting from three separate modifications to the current K-12 employees' benefits array. The projections provided have received much attention as State policymakers work to address budget issues associated with the economic downturn. The Health Care Authority's directive for this report includes an analysis of potential administrative savings that could result through the creation of a single statewide risk pool and associated consolidated K-12 public school employees' benefits purchasing system.

The three options discussed in the HayGroup® report were:

1. Streamline the funding stream.
2. Standardize medical coverage levels for K-12 employees.
3. Restructure the health benefits system.

STREAMLINING THE FUNDING STREAM

Three primary changes to the current K-12 employee benefits array are outlined in the HayGroup® report to reduce the complexity of the system and better align it to serve the current needs of the State:

1. Ensure the stability of funding pools by reducing the number from approximately 1,200 to 500 or less.
2. Align state funding with employee eligibility (several stipulations are delineated).
3. Reform retiree medical "remittance" system.

The combination of the three changes is anticipated by the HayGroup® to modestly reduce administrative costs at the local district level, principally by reducing the administrative burden associated with the local funding pools. **No estimated dollar amount was specified for the anticipated reduced administrative costs.**

Because broker fees and commissions draw attention, it is important to note that the HayGroup® **did not** address broker fees and commissions as an element of this option and no estimate was given of current costs in the K-12 employee benefits array associated with such fees and commissions.

[Note: The HayGroup® report does contain a reference to brokerage fees in Appendix C specific to the contract provisions between the Washington Education Association and Premera BlueCross. A per

subscriber per month amount is reported on page C-OIC-12 and an estimated non-claims charge is calculated by the HayGroup® on page C-7.]

STANDARDIZE MEDICAL COVERAGE LEVELS FOR K-12 EMPLOYEES

Cost savings up to $300 million were estimated by the HayGroup® by standardizing medical coverage to the Silver plan (as defined by the Patient Protection and Affordable Care Act or PPACA) in the set of four benefit tiers to be used in health insurance exchanges beginning in 2014. Among the four tiers the Silver plan has the second lowest relative value and has a substantially lower relative value than the PEBB program Uniform Medical Plan and the majority of the WEA-Premera plans. Reducing the value of a benefit plan equates to increasing the employee point of service cost share obligation or reducing the services covered. Savings resulting from reduced plan value are **not administrative savings**.

RESTRUCTURE THE HEALTH BENEFITS SYSTEM

The third modification described by the HayGroup® involves consolidating the current K-12 employee benefits array into a statewide, **self-funded** plan for school employees. The key wording here is self-funded from the perspective of the cost savings projected by the HayGroup®. As noted by Aon Hewitt during the 2010 legislative session, the $29 million to $64 million estimated cost savings did not take into account surplus funds that would be necessary to establish reserves at the targeted level associated with a state administered self-funded medical plan (approximately $275 million for a consolidated purchasing system serving all K-12 districts).

HEALTH CARE AUTHORITY DATA RESEARCH

During development of this report, the Health Care Authority attempted to further explore the potential for administrative savings but had limited success due to the lack of available data about administrative costs in the current K-12 employee benefits array. Attempts to obtain detailed information about administrative cost centers through the school districts was unsuccessful because the vast majority of the insurance benefit plans are fully-insured and most administrative costs are built into the plan premiums. The remainder of administrative costs incurred directly by districts for internal operations are often not segregated out as benefit-associated costs because benefits administration is blended with other payroll, financing, and human resource operations.

Attempts to obtain detailed administrative cost data from the insurance sponsors and carriers was unsuccessful due to resistance of these entities to release data they consider to be proprietary or because their contractual arrangements with client school districts do not require release of this information. Inquiries to the Office of the Insurance Commissioner revealed that in the case of the WEA-sponsored association plan that serves over 60% of current school district employee subscribers, the Office of the Insurance Commission does not at this time have significant regulatory authority over that plan and therefore plan costs are not available through that Office.

Due to the absence of data, no data-based representation of the current administrative costs is available for this report.

OTHER INFORMATION AVAILABLE ABOUT ADMINISTRATIVE COSTS

Because of the high interest in administrative costs and potential savings resulting from moving to a consolidated purchasing system, the Health Care Authority researched other sources of information that may provide additional insight into the issue. Two sources were researched:

1. Entities functioning as brokers for districts
2. Reported experience of the Oregon Educators Benefits Board purchasing system

ENTITIES FUNCTIONING AS BROKERS FOR DISTRICTS

Members of the project Advisory Team representing brokers serving the current K-12 public school system were asked to provide information about the range of fees typically involved. All individuals were responsive to the request with meaningful information, recognizing the information is proprietary in nature and therefore the responses are generalized.

Some key points noted are:

1. There are two primary compensation methods: fee-based compensation and compensation as a percentage of gross premiums.
    a. As a general rule fee-based groups tend to be larger and capable of administering a separate fee structure from the premium, but in some cases it is added to the group's overall premium.
    b. Generally, smaller districts or districts with carriers that will only compensate a broker through a percentage of gross premiums utilize that method.
2. The amount of the fee is a direct reflection of the time that is required to meet the client's identified needs.
    a. The needs of the clients vary based on a number of factors including their size, level of sophistication, resources of their internal staff, the specific services that they require, etc.
    b. For example, voluntary products that require a larger broker role in enrollment and member service have higher compensation rates.
3. Compensation rates for the majority of cases fall within a range of <1% to 2% of the total premium.
    a. For smaller districts the range may move up to 2% to 4%.
    b. There are outliers that approach the 5% level due to increased complexity associated with self-funded plans, voluntary products, etc.
4. The services covered by fees are broader than just the "purchasing" of benefit plans on behalf of districts. Entities providing broker services may cover the majority of functions associated with administering an employees' benefits plan.

[Note: For purposes of estimating the cost of broker compensation in the current K-12 employee benefits array, the total medical expenditures for 2010-11 were approximately $1 billion.]

REPORTED EXPERIENCE OF THE OREGON EDUCATORS BENEFITS BOARD

The Oregon Educators Benefits Board purchasing system has been operational for a sufficient amount of time to begin to document actual and projected cost-savings based on a system that has had time to stabilize to some degree. Representatives of the Oregon Educators Benefits Board shared their most recent finding by their actuarial consultant. That report is contained in Appendix E.

CONSOLIDATED K-12 PURCHASING SYSTEM

One of the objectives of the implementation plan is to simplify work in the districts. The planned online enrollment tool will save manual data entry of enrollment forms, and will reduce errors and re-work at the district level. The data entry savings also are gained at the benefit carrier level. Many districts send enrollment forms to the carriers for re-entry of data. As the result of more efficient administrative processes related to district interactions with carriers, the Health Care Authority can inform carriers of the potential administrative cost savings during benefit plan premium rate negotiations, and the expectation that these savings to carriers be considered during their preparation of proposed premiums.

While the online enrollment tool will save some time, it is not expected to lead to an FTE reduction in any school district. Most districts are of the size where HR/Payroll people have varied job responsibilities and the elimination of data entry will free up those people for other, higher value work, but will not allow for an FTE reduction.

The State of Washington undertook a successful dependent eligibility verification initiative in 2010 that resulted in identification and removal of a number of ineligible dependents. To the degree that work has not been done in the K 12 program, it is expected that savings in the K-12 system similar to those identified with state employees participating in the PEBB program may be possible. This is a future initiative, and not part of the current scope.

TIMING OF SAVINGS

Meaningful savings that result from the legislature authorizing the creation of a consolidated public school employees' benefits purchasing system will be realized as reduced costs **after the consolidated purchasing system is functioning**. In subsequent years, the level of savings are anticipated to increase, as experienced by Oregon, as elements of administrative simplification are rolled out, elements of system wide utilization management are implemented, and additional services previously performed by contractors and consultants are eliminated, etc.

ATTRIBUTES OF THE CURRENT K-12 SYSTEM

The Washington health care market is dynamic with numerous individual and collaborative efforts underway to reform the health care delivery system in ways that increase access to quality, affordable health care by all citizens of the state. The existing K-12 array of employees' health benefits programs are not sitting separate from this dynamic market and are not static programs unresponsive to and unaffected by health reform efforts. Throughout the development of this report, examples were identified where individual districts, small groups of districts, and individual benefit plan sponsors and carriers have successfully implemented changes within the existing K-12 employee benefits environment that have achieved improvements in support of the goals identified for a consolidated purchasing system.

INDIVIDUAL DISTRICT IMPROVEMENTS

During interviews with project Advisory Team participants, a number of examples were noted where individual school districts have incorporated various combinations of the features described throughout this report. A summary of a set of these interviews is presented in the Case Studies chapter.

Even though each district has approached health benefits improvement differently, there are commonalities across them that have formed the basis for improvement. The following core features were identified and are consistent with the Health Care Authority design proposal contained in this report:

1. Uniform policies are set by a board, committee, or other entity that to establish consistent district-wide design and operations of the health benefits program.
2. District officials and employees have structured their health benefits negotiation processes to support and facilitate the policy board and its decisions.
3. Sufficient staff resources are dedicated to administration of the health benefits program to organize and analyze expenditures and benefits utilization experience to support informed purchasing decisions. This feature is usually associated with larger district size or formal organization of multiple smaller districts into a single health benefits purchasing arrangement. Resources are available though district staff, health benefits consultants/contractors, or a combination of the two.
4. Access to a common set of health benefit plans by all employees.
5. A single risk pool or a small number of risk pools achieved by combination of bargaining unit pools into consolidated employee group pools.
6. Higher degrees of standardization in employer/employee premium cost sharing to achieve affordable benefits for all employees, including those covering dependents.

HEALTH BENEFITS IN RELATION TO OTHER HUMAN RESOURCES DECISIONS

A common and consistent message delivered by the Advisory Team throughout the project emphasized the integral role health benefits play in negotiations between the employer and employees. Of particular note are:

1. In many cases, current employee health benefits design are the result of trade-offs across all employee compensation and benefits. Changes to health benefits resulting from transition to a single statewide health benefits structure has the potential for significant impact to those integrated negotiated arrangements. If the decision is made to move to a consolidated health benefits purchasing system, time will be needed to allow districts and employee bargaining units to adjust other elements of the integrated bargaining arrangement.
2. Health benefits are just one of several aspects of State funding to K-12 school districts. As the details of a consolidated K-12 public school employees' health benefits purchasing system are further developed, the relationship of employee benefits funding as an element of overall funding should be evaluated.

BENEFITS CONSULTANTS AND CONTRACTORS

Because administration of employee health benefits is just one of many responsibilities of public school districts and involves aspects that cross district functions, including human resources, payroll, accounting, etc, district administration often employ the services of benefits consultants and contractors to perform any combination of activities. This is true of districts of all sizes with the range of contracted services varying widely beyond the single role of "purchasing" of benefit plans on behalf of districts.

Information provided by school district human resources personnel demonstrates the nature and range of services currently provided by benefits consultants and contractors:

1. Developing benefits communications.
2. Conducting new hire benefits orientations.
3. Managing open enrollment processes.
4. Processing enrollments and terminations for active, self-pay and COBRA enrollees.
5. Reconciling monthly insurance billings.
6. Producing detailed, clear reports with commentary and interpretation.
7. Providing personal confidential advocacy services for employees involving detailed research, contract interpretation, and negotiation to get medical and disability claims paid.
8. Supporting the work of governing boards, policy committees, etc. to inform benefit plan designs for all types of covered benefits.

YEAR-ROUND ACTIVITIES OF BENEFIT PLAN CARRIERS TO SUPPORT EMPLOYEE INFORMED CHOICE

Health benefits carriers serve as the third partner with the district staff and benefit consultants and contractors in assuring employees receive education about the health benefits available to them and the features that differentiate available plans from each other so each employee has the opportunity to make an informed choice that best suits his or her situation. The education and outreach is a year round process culminating in the annual open enrollment process.

SCHOOL EMPLOYEES ARE ROLE MODELS FOR STUDENTS

The Governor and Legislature have stressed the importance of employee wellness as a contributor to workplace productivity and reduced health care costs. In addition, the Governor has stressed the important role state agency leaders play in modeling healthy behavior and advancing the message of personal responsibility for individual health status.

School district officials on the project team pointed out that a very similar scenario plays out on a wider basis where school employees are impacting students and communities on a day to day basis. The school employees are the bread and butter of many smaller communities and their wellness is important to both the schools as employers and to the students as role models. Having access to health benefits that promote wellness, prevention, chronic disease management, and healthy lifestyle choices must be a priority for the employees' benefits system in whatever form it takes.

2014-15 IMPLEMENTATION OPTION

This discussion is included in the report in the interest of assuring successful, sustainable implementation of a quality, high performing consolidated K-12 public school employees' benefits purchasing system. As noted in the report Introduction, this is an issue of importance to all stakeholders. The intent in presenting this information is to generate discussion of options.

The primary implementation strategy presented in report Volume two delineates the major activities necessary to successfully prepare the consolidated K-12 public school employees' benefits purchasing system for the 2013-14 school year. The time period for this implementation runs from April 2012 through September 2013, a span of 17 months. In order to complete all the necessary activities in this amount of time will require activities that would normally run in sequence to overlap in varying degrees.

For example, with only 17 months available, the Health Care Authority will have to begin the process to design the initial benefit plan portfolio and initiate a competitive procurement for plan carriers concurrent with putting the governing board in place. To assure school district officials and employee representatives have input into the benefit design, a transition stakeholder advisory team will need to substitute.

The following features of the consolidated purchasing system could benefit from an extended implementation period:

1. Involvement of a new governing board in initial policy development, benefit plan design and benefit plan carrier selection;
2. The sequence of activities from portfolio plan design through insurance plan carrier selection and contract implementation;
3. The sequence of activities from benefit plan competitive bidding through budget projection development through legislative budget allocation.
4. Purchasing system/District/Carrier data exchange systems development and testing.

One other factor that is worth considering is the coincidental timing of the targeted October 2013 implementation date for the consolidated K-12 public school employees' benefits purchasing system and the January 2014 implementation date for major aspects of national health reform. Postponing implementation of the purchasing system would allow time to evaluate the final versions of the 2014 health reform requirements and adjust the purchasing system design to assure full compliance.

CASE STUDIES AND SCHOOL DISTRICT FOCUSED INTERVIEWS

CASE STUDIES

To further help inform legislators, case studies are presented on three States that have previously tackled their own K-12 employee health benefits challenges: Oregon, Texas, and New Jersey.

The common theme for these States' systems is that each state created a health benefits system for their K-12 school employees that is separate from the health benefits system provided to their State employees.

One state has a mandatory program, one offers a combination of mandatory and voluntary (depending on district size), and one state provides a completely voluntary program.

A. The **Oregon** Educators Benefit Board was established in 2007. Currently providing coverage to 150,000 employees and their dependents, the OEBB has significant regulatory, budgeting and administrative responsibility. It is mandatory for school districts to participate in the OEBB, with some exceptions that must be approved by the OEBB.

B. The **Texas** Retirement System-Active Care was established in 2001 and provides coverage for almost 75% of the state's 650,000 K-12 employees in 90% of 1,257 school districts. Participation is mandatory for some school districts and optional for others.

C. The **New Jersey** School Employees' Health Benefits Program was created in 2007 and is administered by the State Division of Pension and Benefits. It is an entirely voluntary benefits program, where the local school employer must adopt a resolution to participate. Approximately 50% of the state's 660 school districts currently participate.

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CASE STUDY: STATE OF OREGON

INTRODUCTION

The Oregon Educators Benefit Board (OEBB) was created in 2007 by the Oregon State Legislature to provide health, dental, vision and other benefits for most of Oregon's school district, educational service district and community college employees. The OEBB has regulatory, budgeting and administrative responsibility for the health benefits plans offered to educational employees.

Currently, just under 150,000 employees and early retirees and their dependents receive health benefits through OEBB. When all districts have entered the program it is expected that OEBB will cover approximately 170,000 people.

The Board offers benefits to K-12 public school employees, and to those who work for education service districts, community colleges and some charter schools, as well. Coverage under the OEBB currently includes a total of 239 education service districts, community colleges, charter schools, and school districts. Of the 239 districts in the State of Oregon, only nine school districts, one education service district, and one community college are not participating as covered entities. Once an entity joins OEBB on a voluntary basis, they must stay in the system.

BACKGROUND

Senate Bill 426 (2007) created the Oregon Educators Benefit Board (OEBB). The Board is charged with designing, implementing and administering a benefits program for employees in Oregon's school and education service districts that provides high-quality benefits at the lowest cost to districts and the taxpayers of Oregon. Community colleges can voluntarily participate in the benefits program as well.

OEBB changes the way K-12 school districts, education service districts (ESDs) and community colleges provide benefits to employees. Historically, these educational entities had purchased plans for employees independently, through one of two health plan trusts or through brokered arrangements. Under OEBB, most of these entities now pool employees together to purchase healthcare and other benefits.

OEBB provides 11 medical plans, four pharmacy options, eight dental plans and five vision plans to the 230-plus educational entities and their employees. The plan designs and benefit components support the Board's vision of providing high-quality benefits to educators at the lowest possible cost.

GOVERNANCE STRUCTURE

In May 2007, the Governor appointed a ten-member Oregon Educators Benefits Board. Because of the Board's authority, the appointments were presented and confirmed by the Oregon State Senate during June 2007. The

original Board member appointments were for terms of between one and four years. Subsequent appointments will be for four-year terms.

Given the Board's tight timeline for designing and implementing a benefits program for Oregon school and education service district employees, the Board met at least twice per month during the first year. This schedule allowed the Board to accomplish its goals and meet the October 1, 2008 implementation date for the program.

The Board's membership includes ten individuals:

1. Two members representing school district boards of directors
2. Two members representing school district management
3. Two members representing non-management employees from the largest labor organization representing district employees, the Oregon Education Association
4. One member representing non-management employees from the second largest labor organization representing district employees, the Oregon School Employees Association
5. One member representing non-management district employees from a labor organization that is not the OEA or OSEA
6. Two members with expertise in health policy and/or risk management

The chair and vice chair are elected by the Board and generally serve two-year terms.

OPERATIONAL STRUCTURE

The OEBB staff is organized into six operational and administrative areas as follows:

1. **Program and Policy:** Leads efforts supporting employee health, cost containment, and evidence based health policy.
2. **Communications:** Oversees all mediums of communications with OEBB stakeholders.
3. **Client services:** Administers MyOEBB, the online benefit management system, and provides technical support. Provides customer service to OEBB members, educational entities administrative staff and the contracted insurance carriers.
4. **Fiscal:** Performs monthly premium collection, reconciliation and pass-through of $1.4 billion biennially using the online MyOEBB system.
5. **Contracts:** Oversees the development, execution and management of all OEBB contracts and ensures their legality.
6. **Administration:** Leads OEBB's strategic planning, policy and ongoing administrative activities. Ensures Board has the resources necessary to meet all statutory requirements and the needs of its members and participating entities.

It should be noted that the OEBB takes seriously its responsibilities to the citizens of Oregon and created an administrative model focused on the development of reporting tools for the evaluation of measurable goals and performance outcomes. Specifically, this has included:

1. Annual customer surveys.
2. Consultant studies and insurance carrier reporting on health outcomes, utilization of preventive and medical services, and costs.
3. Ad Hoc reporting through the OEBB's online member benefit management system.

WHO IS ELIGIBLE?

According to the OEBB, an "active eligible employee" means an employee of an OEBB participating organization that meets one of the following criteria:

1. Employed or is in a job-sharing position on a half time or greater basis.
2. Meets the definition of an eligible employee under a separate OEBB rule or under a collective bargaining agreement or documented district policy in effect on January 31, 2008.
3. An employee of a community college who is covered under a collectively bargained contract and has worked a class load of between 25 percent and 49 percent for a minimum period of two years and is expected to continue to work a class load of at least 25 percent.

ENROLLMENT SUCCESS

As an example of efficiencies achieved by the OEBB, the number of medical plan designs offered to education employees was streamlined from an estimated 88 plans to nine plan designs.

OEBB originally anticipated enrolling 65,000 members (22,000 district employees and their eligible dependents) during the first year of a three-year implementation period (October 1, 2008, 2009 and 2010). In fact, during the first year's open enrollment period, 145,645 people were enrolled for OEBB benefits. This included 61,657 subscribers and 83,988 dependents. Consistent enrollment numbers have been achieved in subsequent years.

SAVINGS: ESTIMATED vs. REALIZED

During the 2007 legislative session, the potential savings from a statewide educators benefit pool was estimated to be a bit more than five percent – approximately $40 million of the $740 million in annual premiums – primarily due to savings in administrative costs.

According to information released in early 2011, the summary of savings actually achieved for active employees and their families for medical, pharmacy, dental and vision benefits is as follows:

2008 – 2009: $39.6 million

2009 – 2010: $40.1 million

2010 – 2011: $45.6 million

Calculations of potential additional savings for current retirees and COBRA beneficiaries, as well as for future OEBB enrollees have not been completed.

The same report in early 2011 documents additional savings for optional benefits that were rolled out to educational employees during October 2009. The savings – under Life, Disability and Accidental Death & Dismemberment insurance plans – have been estimated as follows:

2009 – 2010: $5.3 million

2010 – 2011: $6.4 million

IS OEBB PARTICIPATION MANDATORY OR VOLUNTARY?

With a few exceptions, all school and education service districts are required to purchase their benefit plans through the OEBB unless they were self-insured or had an independent health trust in place on December 31, 2006.

Community colleges and certain charter schools are allowed to voluntarily purchase benefits through OEBB. Once joining OEBB, there are no opt out provisions. To date, 16 of the 17 community colleges and 13 charter schools have joined.

Beginning in October 2010, if a self-insured district or other district not yet participating in OEBB wants to continue providing benefit plans other than those offered by the OEBB, it must submit an application to be excluded from the Board's plans. The submitted application must show that the premiums for the benefit plans provided or contracted for the district are equal to or less than the premiums for comparable benefit plans provided by the Board.

During 2011, there was discussion by different members of the Oregon legislature about tweaking the OEBB's parameters (e.g. allowing ongoing opt-in/opt-out or letting smaller districts out of the mandatory pool), but no legislation was introduced and no action was taken on any of the issues.

WHAT KIND OF OVERSIGHT OF THE OEBB IS IN PLACE?

Under the 2007 legislation that established the OEBB, a Task Force on Educator Health Benefits was created. The Task Force consists of six members: one from the Senate, one from the House of Representatives, one who is a district employee represented by a labor organization, one who is a district

management employee and two who are not OEBB participants and who have expertise in health insurance or employee benefits plan design or administration.

The Task Force is expected to review the benefit plans and administration provided by the

OEBB to determine the cost savings created by the mandatory pool and submit a report to an interim committee on education or public employment no later than October 1, 2012.

COLLECTIVE BARGAINING

The mandated movement to the OEBB benefits program aligned with the end of the collective bargaining agreements signed with applicable education entities. The governance structure of the OEBB ensures that all parties – including employee representatives – are part of the decision-making process related to benefit design.

During the initial year's implementation, the OEBB paid attention to providing a full-range of plan design choices, and this helped minimize concerns that may otherwise have been raised by collective bargaining units.

During the last two years, a number of additional benefits have been added to the plan designs, such as free weight management, free smoking cessation, free preventative care, and free or low co-pay office visits for employees with chronic illnesses. Even while simultaneously adding value-based tiers, employees have generally been receptive to these additions.

Contributions toward coverage are decided through the collective bargaining process and, in most entities, employees participate in making the decision of which plans are available for employee consideration during the annual open enrollment period.

CHALLENGES AND LESSONS

A. **Outreach & Customer Service:** The size and geographic disbursement of the larger than anticipated enrollment during the OEBB's first year stretched staff and carriers to their limits. OEBB staff and carriers spent a significant amount of time during May and June 2008 traveling to districts throughout the state to explain the new program and plan offerings available to districts to select and offer to their employees.

   In fact, through 2011, OEBB staff continues to travel to entities each May and June to explain benefit program and plan design changes to allow employee groups to decide which benefit plans will be available for employees to consider during the annual open enrollment period.

   OEBB partners with both carriers and educational entities in providing customer service.

OEBB created and maintains the online enrollment system that allows carriers to receive enrollment and eligibility information electronically and produces electronic invoices to entities for premiums due each month.

OEBB assists employees, covered dependents and participating entities with questions regarding enrollment, eligibility, and the benefits program in general. Carriers assist members with claim- and coverage-specific questions.

Depending on the entity, employees receive assistance with enrollment, eligibility, and the benefits program in general through an entity benefit representative. Entities also process payroll deductions for benefit selections as shown in the online benefit management system, MyOEBB.

During the initial statewide enrollment period (August and September 2008), OEBB staff and carriers were again on the road visiting more than 100 districts and entities to explain benefit options and the online enrollment process to new OEBB members and staff of educational entities. More than 98 percent of the employees enrolled for benefits online during the month-long enrollment period.

OEBB staff and carriers continue to travel throughout the state during August and September to educate employees about their benefits program, benefit plans, and various benefit-related topics during the annual open enrollment period.

In terms of educating employees, the OEBB created an Outreach network made up of representatives from educational entities to assist with crafting and distributing messages explaining the move to OEBB.

Communications included monthly newsletters and emails distributed to all participating entity employees, frequent messages to entity leadership and staff responsible for human resource, payroll and systems administration, and posts to the newly created OEBB website.

While OEBB had a budgeted line item for communications and education, it was not any higher for implementation than it is for ongoing activities.

The carriers selected offered strong networks and expanded the availability of a health maintenance organization-type of plan into areas of Oregon that traditionally have not had access to the benefit levels offered by such a plan.

The MyOEBB system was developed in five months (April through August 2008) beginning with the migration of more than 61,000 employee records from educational entities around the state. The enrollment period concluded with more than 98 percent of all subscribers self-enrolled for benefits using the online system.

B. **Automation:** A priority at the onset of OEBB was to offer an improved administrative model to program participants. The Board was very successful in implementing efficiencies during

the 2008 enrollment period that included ability to enroll online, manage eligibility in real time for educational entities, and pay premiums via an automatic electronic payment system with electronic reporting for reconciling invoices.

C. **Wide geographic coverage:** OEBB conducted statewide training and presented plan options to every educational entity in Oregon. OEBB also selected carriers that offered strong networks and expanded the availability of a health maintenance organization-type of plan into areas of Oregon that traditionally have not had access to the benefit levels offered by such a plan.

D. **Implementation:** Implementing a program the size and scope of the Oregon Educators Benefit Board (OEBB) benefits program typically takes at least two years. The implementation timeline depended on the availability and expertise of staff, consultants and board members. The abbreviated timeline required rigorous planning and an orchestrated coordination of efforts.

E. **Costs:** With a drop in school enrollment since the start of OEBB, key stakeholders are worried about the future of the program. Some school districts have argued that OEBB has already missed the mark in its intended purpose, complaining about increased costs in premium co-shares, deductibles, and out-of-pocket costs.

   OEBB staff believes the drop in enrollment has been related to the poor national and regional economies and subsequent education entity layoffs. The cost increases experienced in Oregon are common in health care but with plan design changes OEBB has moderated increases. The OEBB's recent overall 1.4 percent increase in premiums is attributed to more informed consumers selecting plans (albeit less costly plans) that more accurately reflect their health and insurance coverage needs.

F. **Breadth of plan design:** The requirement that plans offered by the OEBB be comparable in benefit design to what was offered across the State was a major challenge as there was such a broad range of plan designs offered prior to the OEBB.

   During the first year, many employees chose to enroll in a plan other than the plan that was considered comparable. This migration was mainly to benefit plans that offered a higher level of benefits due to the lower premiums available following the Request for Proposal procurement process.

   Migration in the subsequent years has been to plans with lower benefit levels and lower premiums. The two plans created to replace the two most popular pre-OEBB benefit plans are now among the lowest in enrollments.

CASE STUDY: STATE OF TEXAS

INTRODUCTION

One of the largest states in the country, Texas has 1,257 school districts with hundreds of thousands of active employees. Today the state offers a public school employees' health benefits program called TRS-ActiveCare that is administered by the Teacher Retirement System of Texas (TRS), the state's largest public retirement system. Established in 2001, TRS-ActiveCare is a separate statewide health system for school district employees independent of the state employees' health plan.

HISTORY

A FAILED PROGRAM

In the early 90s, TRS was authorized to set up a health coverage program for public schools. The program was individually rated based on risk and census for a particular school district. Unfortunately, the program was not structured to support districts in a consistent manner throughout the state. A voluntary program from the start, districts could enter and leave the program as they pleased. This resulted in an unstable program and a regular drain on resources. The final district dropped out in 1999 and thus the state decided to shut down the program permanently.

Yet the Texas Legislature concluded that one uniform health coverage program for public school employees was needed. The prevailing marketplace situation prevented smaller districts from getting coverage at affordable rates, and larger districts were jumping from carrier to carrier. Having learned lessons from the failures of the TRS voluntary program of the 90s, the State Legislature was ready to try again.

TRS-ACTIVECARE

In 2001, the 77th Texas Legislature passed legislation authorizing TRS to develop TRS-ActiveCare. The new program went into effect September 1, 2002. The Legislature said most pressing issues were in smaller districts with 500 or fewer employees. School administrators in these districts found it difficult to find affordable coverage and sometimes could not find carriers at all. The early version of the program required that districts with fewer than 500 public school employees participate, which initially included about 700 districts, and did not allow larger districts. However, the law also allowed for the program to be offered to large school districts if the governing body of TRS, the TRS Board of Trustees (TRS Board), determined that it was economically and administratively feasible to do so.

A few exceptions to participation existed for these smaller districts. If the were under a multi-year contract, they could wait for the contract to expire to join TRS-ActiveCare, and they could stay out entirely if they were already in a larger risk-sharing pool of multiple districts. Once districts enter the program, however, they are required to stay permanently in order to eliminate the risk and financial drain of districts moving in and out of the program.

The Legislature recognized that starting the program required an initial investment of funds. Rather than appropriating funds, they authorized a loan from retiree health program to TRS-ActiveCare. The loan was granted with the stipulation that it be paid back in three years. Toward the beginning of the second plan year, the TRS Board of Trustees paid off the loan of 42 million dollars plus interest.

With the program debt free, the TRS Board of Trustees (TRS Board) determined it was economically and administratively feasible to open up the program to all districts regardless of size. Subsequently, participation has grown to 1122 school districts—a nearly 90% participation rate—and includes the second, third and fourth largest districts. Today, 470,000 lives are covered by the program.

The state briefly considered merging school employees into the health benefits program for state employees and decided against it. The state employee program reportedly did not want to include school employees, for unclear reasons. Additionally, the state has always tried to maintain an arm's length with school employees given that they are not truly state employees—they're employees of independent school districts.

ELIGIBILITY

Employees of participating school districts or entities (e.g., educational service districts) who are actively contributing to the Teachers Retirement System (TRS) or who are employed 10 or more regularly scheduled hours each week and their dependents are eligible to participate in TRS-ActiveCare. Coverage is not limited to teachers and is available to all types of district employees, including, administrative personnel, permanent substitutes, bus drivers, librarians, crossing guards, cafeteria workers, and high school or college students. True on-call substitutes, independent contractors, and volunteers are not employees and are therefore not eligible for TRS-ActiveCare coverage.

PARTICIPATION REQUIREMENTS

TRS-ActiveCare is a hybrid program with both mandatory and voluntary participation, depending on school district employee population size. As of September 1, 2003, Texas law required that active employees of all school districts with fewer than 500 employees participate in TRS-ActiveCare, unless the school district was already self-insured as of January 1, 2001. School districts with more than 500 but not more than 1,000 employees have the option of participating in TRS-ActiveCare, but once they elect to participate, they cannot leave the program. Effective September 1, 2005 active employees of school districts with more than 500 employees are permitted, but not required, to participate in TRS-ActiveCare. Of the 1,257 districts/entities eligible to participate in TRS-ActiveCare, nearly 90% percent, or 1,122, now do so.

No incentives are intentionally offered to encourage participation by the larger districts. TRS-ActiveCare has become a cost-effective and appealing program with better than market rate options, which serve as an incentive. For school districts considering voluntary participation, the question has shifted from "Should we?" to "When should we?"

GOVERNANCE

The TRS Board of Trustees oversees TRS-ActiveCare. The TRS Board also oversees the pension trust fund and the retiree health plan trust fund. The board is composed of nine trustees that are appointed to staggered terms of six years. The board is composed of:

1. Three trustees directly appointed by the governor.
2. Two trustees appointed by the governor from a list prepared by the State Board of Education.
3. Two trustees appointed by the governor from the three public school district active member candidates who have been nominated for each position by employees of public school districts.
4. One trustee appointed by the governor from the three higher education active member candidates nominated by employees of institutions of higher education.
5. One trustee appointed by the governor from the three retired member candidates who are nominated by retired TRS members.

PROGRAM FUNDING

The program is funded through several sources. First, school districts are required to contribute a minimum of $150 per month per covered TRS member (school districts may choose to contribute more). By definition, a "covered TRS member" is a school employee working at least 20 hours per week and thus contributing to the state's Teacher Retirement System. If an employee is working less than 20 hours, the school district is not required to contribute the $150 per month to their health care benefits. Second, the state contributes $75 per month per covered TRS member through school finance formulas. This money goes to school districts regardless of whether they are participating in TRS-ActiveCare. Third, the employee contributes the amount remaining after the employer and state contributions for the plan he or she has selected. Additional funding sources are investment income and reimbursements related to the American Recovery and Reinvestment Act.

COSTS

Participating districts are required to pay 100% of premium cost by census to TRS-ActiveCare. The state's contribution has not gone up over time, so out of pocket costs for employees have gone up. This has reportedly become an issue with employees, but they are taking it up with the Legislature, not TRS-ActiveCare since it bears no responsibility for how benefits are funded.

COLLECTIVE BARGAINING

The role of collective bargaining around school employee health benefits is insignificant compared to other states. Texas is a right to work state with minimal union penetration in schools. And where unions do exist, they reportedly support participating in the plan—health benefits come off the table, and they can focus on compensation and working conditions.

BENEFITS OFFERED

TRS-ActiveCare initially offered three plan options with no pre-existing exclusions for initial enrollment into a plan. By statute, the program was actually only required to offer catastrophic and primary coverage, but initial plans were designed to be actuarially on par with the relatively

robust plans available to state employees. TRS-ActiveCare created a mid-coverage plan that is used by 75% of enrollees. A fourth high-deductible PPO plan was recently created for school districts that offer health savings accounts.

Today the program offers a variety of options to participants providing medical and prescription coverage:

1. Four PPO plan options are available and administered by Blue Cross and Blue Shield of Texas and Medco
2. Three HMO options are available through FirstCare Health Plans, Scott & White Health Plan, and Valley Baptist Health Plans.

The HMO options are new for the 2011-2012 school year and will provide additional plan choices to the employees of participating entities in areas served by these HMOs. These employees will have the choice to select TRS-ActiveCare coverage under one of the PPO plans or through the authorized HMO serving their part of the state. TRS-ActiveCare participants can change plans each year during the annual open enrollment period.

TRS-ActiveCare offers a separate Long Term Care insurance program for both active public school employees and school employee retirees. It is an employee-pay-all program.

CHALLENGES AND SUCCESSES

A. **Implementation:** The first challenge the program faced at the start was selecting a health plan administrator and a pharmacy benefit manager. They needed two primary things from a plan administrator. One—a statewide provider network that could offer access to healthcare across the state. They needed to have a network meeting the criteria in the Department of Insurance code for preferred provider organizations, with primary care physicians within certain miles of participating school districts. Two—the ability to offer claims adjudication services. The process of finding those took time and was challenging.

The second and most difficult challenge the program faced initially was setting up the flow of money and the infrastructure for the program. A complex flow of information and dollars needed to be navigated. Today, enrollment and some billing features are handled online. The system reportedly "works like a Swiss watch." This year the program added 40,000 individuals without any issue.

B. **Cost Savings:** Texas did not achieve any costs savings, nor did they expect to, by establishing TRS-ActiveCare. The goal of the original legislation was to provide broad coverage to public school employees, not to reduce costs. Prior to the legislation, the state did not contribute to school employee health benefits. The $75 per month contribution by the state for health benefits was new and increased state costs. For some districts, the program also increased their costs, but now they also have access to affordable health care coverage. TRS-ActiveCare staff believes that, had the state put money into school employee health benefits prior to TRS-ActiveCare's establishment, a cost savings would have been realized.

C. **Portability:** When an employee moves to another district participating in the TRS-ActiveCare program, their coverage follows them. The program simply sends its bill to a different district, and it is an easy administrative change. TRS-ActiveCare views this as a success of the program and a benefit to school employees.

CASE STUDY: STATE OF NEW JERSEY

INTRODUCTION

New Jersey's School Employees' Health Benefits Program (SEHBP) offers medical and prescription drug coverage to qualified school employees and retirees and their eligible dependents. It is an entirely voluntary benefits program, for which local employers must adopt a resolution to participate. The New Jersey State Division of Pensions and Benefits, specifically the Health Benefits Bureau and the Bureau of Policy and Planning, is responsible for the daily administrative activities of the SEHBP, as well as the health benefits program for state employees—the State Health Benefits Program (SHBP). SEHBP is a self-funded program in which the Division is able to obtain an attractive plan price for the size of its population and simply pays an ASO (administrative services only) fee to carriers. A low-risk relationship for carriers, they are able to negotiate lower prices with medical facilities and providers for the program.

HISTORY

Prior to 2008, New Jersey school districts had the option to participate in the health benefits program for state employees. In 2007, a separate program for school employees was established by the state legislature and launched the following year. The School Employees' Health Benefits Program (SEHBP) was created in part because the administration wanted to terminate the expensive indemnity plan it offered through the state employees program. It also wanted to introduce new, more cost effective health plans and require participants to share in the premiums. With push back from the teachers' union, the one way to gain buy in for these changes was to establish a school-employees-only program overseen by a commission that granted unions greater representation.

ELIGIBILITY

All full-time employees of school districts, school boards and county colleges are eligible for SEHBP coverage through their local employer. Part-time adjunct faculty of county colleges are also eligible, but they must pay the full cost of premiums. Each participating local employer defines the minimum hours required for full-time by a resolution filed with the Division of Pensions and Benefits, but it can be no less than 25 hours per week or more if required by contract or resolution. Employment must also be for 12 months per year except for employees whose usual work schedule is 10 months per year (the standard school year). Dependents are also eligible, including those of civil unions and domestic partnerships.

A VOLUNTARY PROGRAM

SEHBP is a fully voluntary program, with approximately 50% of the state's 660 school districts participating. The State offers no incentives to participate other than lower costs. Premiums through SEHBP are reportedly very competitive with the open market. Many of the state's districts are very small and would not be able to get the prices available through SEHBP. The Division of Pensions and Benefits takes a proactive approach, managing the plans aggressively to hold down costs. SEHBP has approximately 97,000 active-employee subscribers and approximately 91,000 retiree subscribers—these numbers do not include total lives covered.

GOVERNANCE

The School Employees' Health Benefits Commission is the executive body established by statute and responsible for operation of the SEHBP. The Commission is responsible for hearing member appeals regarding claim denials, determining eligibility criteria and setting rates for the program's plans. This year, the Commission established a benefit design committee that will explore and be responsible for creating and modifying plans. The nine-member body includes:

- The New Jersey State Treasurer
- The New Jersey Commissioner of the Department of Banking and Insurance
- One Governor appointee
- One Governor appointee from New Jersey School Board Association nominations
- Three Governor appointees from New Jersey Education Association nominations
- One Governor appointee from New Jersey State AFL-CIO nominations
- A chairperson appointed by the Governor from nominations jointly submitted by at least six of the other eight members of the commission.

The Director of the Division of Pensions and Benefits serves as secretary of the Commission.

FUNDING AND PAYMENT

New Jersey does not allocate funding to help cover the cost of school employee health benefits. Local employers (i.e., school districts) cost-share with employees based on union agreements. In 2010, a controversial law was passed requiring that employees pay 1.5% of their salary toward premiums. This year, determination of the premium requirement shifted again to be based on salary tiers. Employees are now required to pay a portion of their premium based on the plan they choose and their salary tier. The more an employee makes, the more they are required to contribute. This structure will be phased in over a four-year period.

Property taxes are a significant source of funding for New Jersey's school system, including local employer contributions to health benefits. New Jersey has one of the highest property tax rates in the country. The administration chose to require that employees pay part of their premiums rather than raise property taxes again to help local employers pay for benefits.

COLLECTIVE BARGAINING

The power to determine eligibility criteria and benefit structure resides with the Division of Pensions and Benefits. Unions are able to negotiate their share of the premium contribution. In some cases, school districts can limit the kinds of plans available to employees through the program, and in those situations, unions can try to negotiate this.

SYSTEM ADMINISTRATION

Many elements of the program are currently administered in house, with an eye toward moving much of it out-of-house in the near future. In addition to carrying out an RFP process for every carrier used, the Division of Pensions and Benefits carries out enrollment—by paper—and handles customer service and some billing functions. Over the last few years, the Division lost one-third of its staff while experiencing an increase in the volume of applications exceeding its ability to respond in a timely way. The Division hopes to contract out many of these functions to a company with capacity to receive online applications and data collection that facilitates broad-based information sharing and benefit comparisons for enrollees.

CHALLENGES AND SUCCESSES

The creation of the SEHBP was hailed as a success. School employees were highly supportive given they would have a stronger voice on the commission leading it and not get lost among state employee representatives with different interests. Under the SHBP, prior to the SEHBP, school employees had only one representative—now they have four union representatives and one employer representative. The program is reportedly well funded and no structural changes are expected moving forward.

Benefit design has been one of the biggest areas of challenge faced by the program. Union interests and cost-effective benefit design have sometimes been difficult to balance.

LESSONS LEARNED

SEHBP staff believes employee contributions and wellness programs are crucial to achieve cost savings. The SEHBP "wrung out all the savings it could with benefit design, disease management and case management" and found that employees needed to be more involved in the cost of their care to prevent runaway usage of benefits and the health care system. SEHBP introduced two high deductible plans this year which they expect will gain more usage as participating employees look at the alternatives and

make more informed choices. Although SEBHP hasn't implemented a wellness program, staff believes the evidence shows it would make a difference in the health of program participants, how they use their benefits and the cost of benefits over time. Union opposition has prevented the implementation of a wellness plan.

SCHOOL DISTRICT FOCUSED INTERVIEWS

Interviews were conducted with a number of school districts to learn how they manage benefit plans, benefits administration and decisions. Our purpose was to:

1. Learn from some districts that have made good progress on some of the same goals of the K-12 project such as equity, cost effectiveness, and transparency.
2. Learn about "as is" district programs to compare and contrast with the PEBB program.
3. To understand current school district systems and operations to be able to describe general impact of a new program.

We talked with seven districts, and partners / associations about various topics including governance, benefit design, eligibility, procurement/contracting, administration, enrollment, customer service, claims payment/ administration, finance, reporting and managing risk pools. Of the seven districts, five were large (all in the top 20), and so the information and feedback we received is skewed towards that segment. We did get input from WASBO, WASA and WSIPC and have attempted to represent medium and small districts as well, but that group was underrepresented in our research.

ACTUARIAL WORK AND BROKER RELATIONSHIPS

Each district engages a broker/actuary to perform various services. In each of the cases, the actuary was responsible for reporting claims experience and making recommendations about plan design. In one case, the broker provided additional services including benefits administration operations (more detail on that in a subsequent section). Most districts engage small brokers for this purpose with the exception of Tacoma and Everett which both work with Mercer. The engagement models differ: some are consulting arrangements (fee), some are commission based, and some are hybrids. Health Care Authority partners with Milliman for actuary services on a consulting basis, rather than a commission.

BENEFIT DESIGN

There is wide variation in how this is accomplished. In some cases, a single board or trust has been formed to design the benefits for the entire employee population. And, in other cases, an advisory board exists to make recommendations to the school district, with the district retaining full responsibility and authority for making benefit design decisions. In some districts, benefit designs are bargained by each individual bargaining unit.

Most districts provide a range of plans with significant differences in coverage and premiums (some up to a 40% difference). Districts indicated that this level of variance is important for them and their employees. Most districts provide at least some options made available through WEA, and some provided those options exclusively. Concern was mentioned about the level of transparency provided by the WEA options.

There were differences among districts about the intent of providing equity, or reduced costs for family coverage. Several were focusing on equity for family coverage. None of the districts provide incentives for employees to opt out of coverage, even if the employee has coverage elsewhere. Some districts are able to provide multiple options for employee only coverage and so there is no incentive for employees to enroll in a lower cost plan. One district reported that over 50% of employees are single subscribers and focused coverage on employees.

GOVERNANCE

As mentioned in the Benefit Design section, there is a significant difference in how benefit design decisions are made and the level of formality or legal structure of the boards/trusts.

K-12 district health benefit governance and authority varies across districts. Here are some examples:

1. Single committees made of up labor and management to develop guiding policy.
2. Some establish uniform standards, processes, etc. across all bargaining groups and management.
3. Trusts that do same as above.
4. Some have advisory committees which inform management with decisions being made by management.

All reported that the key success factors for the governing body or advisory committees were: collaboration, trust, benefits knowledge of members and a clear decision-making process.

Districts that have simplified benefit design process include Tacoma, Everett, Seattle, and Spokane and Northshore.

ELIGIBILITY

In general, there appears to be at least two ways of determining eligibility based on the type of job. For some positions, eligibility is based on a full time schedule and for others on a school year schedule. In some cases, eligibility is determined though bargaining. Other districts have standard eligibility policies and 0.5 FTE is the standard, although one district includes 0.3 FTE and above. The required number of hours worked to achieve 0.5 FTE varies based on the employee's role.

Verification of eligibility processes differ. A small number of districts that have advanced information systems and simpler eligibility rules have automated much of this process. Other districts manually

calculate, analyze, and determine eligibility. Eligibility verification and managing changes in eligibility is a complex process and requires a significant amount of administration. It was suggested that work provides little additional value and would benefit districts if simplified.

INSURANCE MODEL

Most districts had insured plans. Two trusts have recently moved from self-insured to insured. One district is still self-insured for most product offerings.

POOLING

Each district performs pooling, and each performs that work differently. The number of pools, the frequency of pool allocation, and the methodology varied. Some districts mentioned a strong desire to simplify or eliminate this process.

OTHER

The smaller and medium sized districts mentioned that there was interest in the program if there were cost savings and if the new program could make benefits administration and operations more efficient. The use of online enrollment would be positive and a reduction in expenses would be welcomed. The lack of buying power, prevalence of unhealthy people, and the lack of incentives to choose a lower cost plan were mentioned.

VOLUME 1 –
APPENDIX

APPENDIX A

Washington K-12 Employees
Actual FTEs by School District
Source: OSPI Report S-275 Personnel Report
2010-2011 School Year

School District	Actual FTEs [1]	Employees
Total	103,852	129,761
Seattle Public Schools	4,945	5,504
Spokane School District	3,151	3,819
Tacoma School District	3,144	3,552
Kent School District	2,598	3,178
Evergreen School District (Clark)	2,502	3,082
Lake Washington School District	2,242	2,742
Vancouver School District	2,236	2,725
Federal Way School District	2,220	2,753
Puyallup School District	1,931	2,453
Highline School District	1,904	2,340
Edmonds School District	1,885	2,407
Northshore School District	1,778	2,205
Bethel School District	1,754	2,161
Bellevue School District	1,739	2,212
Everett School District	1,683	2,018
Issaquah School District	1,540	1,895
Kennewick School District	1,526	1,870
Pasco School District	1,521	1,850
Yakima School District	1,502	1,729
Auburn School District	1,411	1,698
Renton School District	1,399	1,725
North Thurston Public Schools	1,369	1,716
Clover Park School District	1,325	1,545
Mukilteo School District	1,310	1,640
Central Valley School District	1,245	1,597
Central Kitsap School District	1,218	1,526
Battle Ground School District	1,200	1,486
Marysville School District	1,107	1,323
Richland School District	1,031	1,254
Bellingham School District	1,018	1,299
South Kitsap School District	981	1,198
Olympia School District	912	1,283
Shoreline School District	879	1,218
Snohomish School District	878	1,148
Mead School District	854	1,116
Peninsula School District	837	1,050
Sumner School District	792	1,007
Moses Lake School District	781	978
Wenatchee School District	781	1,023
Franklin Pierce School District	777	968
North Kitsap School District	679	919
Lake Stevens School District	674	871
Longview School District	673	801

(1) The actual FTEs reflect the sum of FTE counts for all employees.

Washington K-12 Employees
Actual FTEs by School District
Source: OSPI Report S-275 Personnel Report
2010-2011 School Year

School District	Actual FTEs [1]	Employees
Tahoma School District	663	798
Sunnyside School District	660	758
Walla Walla Public Schools	650	813
Mount Vernon School District	641	846
Tumwater School District	640	841
Monroe School District	581	726
Bremerton School District	548	662
Camas School District	544	706
Yelm School District	531	690
Snoqualmie Valley School District	524	656
Ferndale School District	521	671
Oak Harbor School District	519	643
University Place School District	514	629
Eastmont School District	511	637
Kelso School District	497	641
Shelton School District	465	558
West Valley School District (Yakima)	465	556
East Valley School District (Spokane)	463	575
Stanwood-Camano School District	456	575
Enumclaw School District	450	569
Arlington School District	438	553
Educational Service District 112	432	579
Cheney School District	430	549
Sedro-Woolley School District	419	540
Port Angeles School District	394	469
Aberdeen School District	390	504
West Valley School District (Spokane)	389	518
Burlington-Edison School District	387	503
Mercer Island School District	382	489
White River School District	376	468
Othello School District	372	459
Bainbridge Island School District	370	498
Toppenish School District	365	425
Wapato School District	357	415
Centralia School District	348	466
Grandview School District	347	431
Selah School District	336	444
Fife School District	325	405
Steilacoom Hist. School District	317	367
Prosser School District	311	394
Washougal School District	305	424
Chehalis School District	297	380
Riverview School District	297	384
Puget Sound Educational Service District 121	297	343
Quincy School District	291	373
Ellensburg School District	288	381

(1) The actual FTEs reflect the sum of FTE counts for all employees.

Washington K-12 Employees
Actual FTEs by School District
Source: OSPI Report S-275 Personnel Report
2010-2011 School Year

School District	Actual FTEs [(1)]	Employees
Clarkston School District	288	380
Tukwila School District	282	354
Educational Service District 113	277	373
East Valley School District (Yakima)	271	343
Quillayute Valley School District	264	360
Lynden School District	260	385
Sequim School District	258	333
Anacortes School District	257	347
Deer Park School District	253	405
Wahluke School District	233	263
North Mason School District	230	286
Colville School District	229	306
Mount Baker School District	229	287
Lakewood School District	227	304
Woodland School District	226	317
Ephrata School District	223	273
Pullman School District	223	295
Omak School District	222	281
North Franklin School District	221	298
Blaine School District	216	280
Rochester School District	210	243
Medical Lake School District	206	272
Hoquiam School District	204	273
Orting School District	197	245
Sultan School District	191	236
Granite Falls School District	190	241
Eatonville School District	187	252
Nooksack Valley School District	184	247
Elma School District	177	219
Riverside School District	165	222
Meridian School District	165	232
Royal School District	158	198
Granger School District	157	183
Kiona-Benton City School District	157	212
Northwest Educational Service District 189	155	178
South Whidbey School District	153	219
Nine Mile Falls School District	152	182
Olympic Educational Service District 114	149	181
Hockinson School District	144	175
Vashon Island School District	143	186
Castle Rock School District	142	194
Port Townsend School District	140	206
Lake Chelan School District	135	181
Naches Valley School District	132	184
Tenino School District	132	180
Cashmere School District	131	174

(1) The actual FTEs reflect the sum of FTE counts for all employees.

Washington K-12 Employees
Actual FTEs by School District
Source: OSPI Report S-275 Personnel Report
2010-2011 School Year

School District	Actual FTEs [1]	Employees
Dieringer School District	131	162
Ridgefield School District	130	160
Mount Adams School District	129	150
Educational Service District 101	126	148
Zillah School District	126	152
Stevenson-Carson School District	125	169
Cascade School District	125	167
Okanogan School District	122	161
Montesano School District	122	174
Highland School District	121	144
Chimacum School District	120	166
White Salmon Valley School District	118	159
Newport School District	115	154
Tonasket School District	112	157
Valley School District	112	139
Goldendale School District	110	145
Warden School District	108	140
Brewster School District	107	130
La Center School District	105	122
Mabton School District	104	126
Educational Service District 105	103	108
Unknown	98	99
Coupeville School District	98	122
Ocean Beach School District	98	135
Chewelah School District	98	122
Finley School District	97	118
Grand Coulee Dam School District	96	137
Kettle Falls School District	95	135
College Place School District	94	115
Freeman School District	91	115
Rainier School District	90	114
Cle Elum-Roslyn School District	90	134
San Juan Island School District	88	123
Wellpinit School District	88	96
Columbia (Walla Walla) School District	87	106
La Conner School District	87	116
Onalaska School District	87	116
Ocosta School District	84	113
Cape Flattery School District	83	107
Bridgeport School District	82	100
Toledo School District	81	108
Pioneer School District	81	98
North Central Educational Service District 171	80	92
Raymond School District	80	112
Orcas Island School District	78	119
Manson School District	77	113

(1) The actual FTEs reflect the sum of FTE counts for all employees.

Washington K-12 Employees
Actual FTEs by School District
Source: OSPI Report S-275 Personnel Report
2010-2011 School Year

School District	Actual FTEs [1]	Employees
South Bend School District	76	101
Kalama School District	76	109
Oroville School District	76	108
Concrete School District	75	107
North Beach School District	75	104
Winlock School District	74	100
Reardan-Edwall School District	73	100
Napavine School District	71	93
Mary Walker School District	69	98
Colfax School District	68	109
Asotin-Anatone School District	67	95
Union Gap School District	66	78
Toutle Lake School District	66	95
Griffin School District	66	87
Kittitas School District	65	83
Mossyrock School District	64	88
Methow Valley School District	63	98
Davenport School District	63	78
Liberty School District	59	94
Darrington School District	57	75
Soap Lake School District	57	76
Educational Service District 123	57	69
White Pass School District	54	81
Dayton School District	54	80
Adna School District	50	65
Hood Canal School District	48	60
Willapa Valley School District	46	63
Wahkiakum School District	45	64
Naselle-Grays River Valley School District	45	70
Republic School District	45	61
Morton School District	43	68
Ritzville School District	43	54
Pomeroy School District	42	73
Entiat School District	42	59
Conway School District	42	57
Waitsburg School District	41	55
Cusick School District	40	62
Selkirk School District	40	57
Waterville School District	39	55
Prescott School District	39	57
Lopez School District	39	57
Lake Quinault School District	38	48
Pateros School District	38	52
Oakville School District	37	57
Quilcene School District	36	53
Northport School District	36	50

(1) The actual FTEs reflect the sum of FTE counts for all employees.

Washington K-12 Employees
Actual FTEs by School District
Source: OSPI Report S-275 Personnel Report
2010-2011 School Year

School District	Actual FTEs [1]	Employees
Taholah School District	36	43
Lyle School District	35	50
Touchet School District	35	42
Columbia (Stevens) School District	35	50
Pe Ell School District	35	49
Rosalia School District	35	49
Wilbur School District	34	50
Inchelium School District	34	46
Crescent School District	34	46
McCleary School District	34	43
Palouse School District	33	47
Lind School District	32	42
Odessa School District	32	50
Curlew School District	31	48
Thorp School District	31	40
Orondo School District	31	42
Tekoa School District	31	43
Coulee-Hartline School District	29	44
St. John School District	28	49
Garfield School District	26	44
Nespelem School District	26	33
Mary M Knight School District	26	32
LaCrosse School District	26	38
Wilson Creek School District	26	34
Harrington School District	25	37
Oakesdale School District	25	34
Creston School District	24	29
Colton School District	23	31
Mansfield School District	22	34
Endicott School District	22	33
Washtucna School District	22	32
Loon Lake School District	22	32
Klickitat School District	21	30
Wishkah Valley School District	21	39
Trout Lake School District	21	34
Sprague School District	21	32
Cosmopolis School District	21	29
Easton School District	20	25
Carbonado School District	20	27
Almira School District	20	27
Orient School District	20	31
Grapeview School District	20	28
Southside School District	20	26
Skykomish School District	20	23
Glenwood School District	20	26
Bickleton School District	19	21

(1) The actual FTEs reflect the sum of FTE counts for all employees.

Washington K-12 Employees
Actual FTEs by School District
Source: OSPI Report S-275 Personnel Report
2010-2011 School Year

School District	Actual FTEs [(1)]	Employees
Wishram School District	19	22
Kahlotus School District	18	23
North River School District	17	18
Summit Valley School District	14	19
Boistfort School District	13	18
Green Mountain School District	11	15
Centerville School District	11	15
Mill A School District	10	16
Skamania School District	10	13
Queets-Clearwater School District	10	12
Onion Creek School District	10	16
Keller School District	10	13
Brinnon School District	9	14
Orchard Prairie School District	8	11
Dixie School District	8	11
Lamont School District	7	12
Steptoe School District	7	10
Palisades School District	7	9
Satsop School District	6	12
Index School District	6	11
Great Northern School District	6	9
Star School District	6	7
Mount Pleasant School District	6	8
Evaline School District	5	8
Roosevelt School District	5	7
Damman School District	5	8
Starbuck School District	5	7
Evergreen School District (Stevens)	4	7
Benge School District	4	8
Stehekin School District	3	6
Paterson School District	1	1
Vader School District	0	0
Shaw Island School District	0	0

(1) The actual FTEs reflect the sum of FTE counts for all employees.

APPENDIX B

K-12 REPORT – PROJECT TEAMS OVERVIEW

To inform the HCA staff responsible for researching and writing the Report to the Legislature, the Health Care Authority drew upon the resources and knowledge of multiple state agencies, school districts, associations of school officials, associations of school employees, legislative staff, and associations and individuals across the K-12 network. These additional individuals represented insurance consultants and brokers, health benefits carriers, as well as Health Care Authority contracted actuarial consultants, communications consultants, and benefits administration consultants.

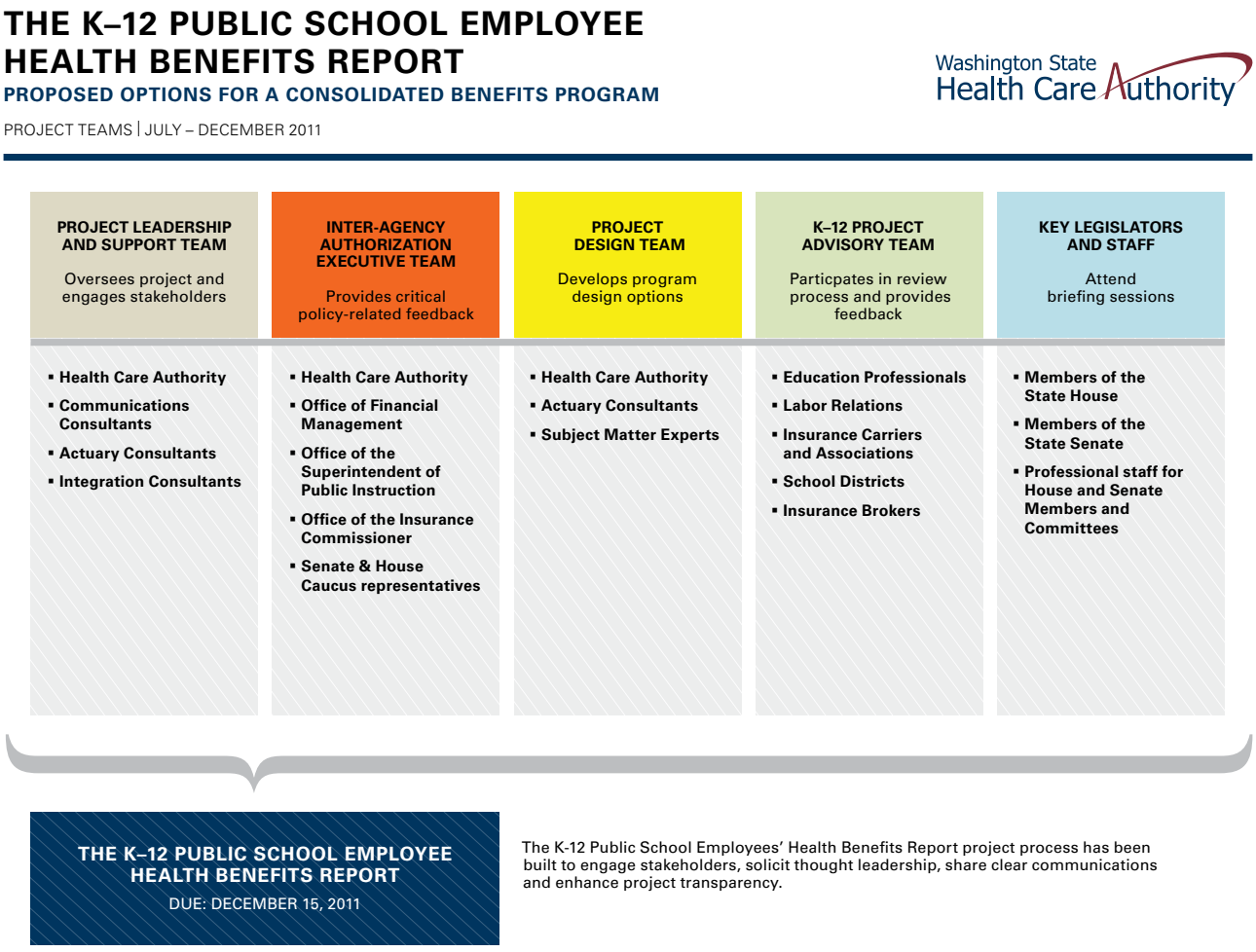
All of these entities and individuals were organized into a project network of five teams to fully address the goals and objectives established for the project and the multiple areas of key importance related to the design of a complex health benefits program.

The network of five teams is depicted in the graphic below.

Much of the detail and accuracy of the final report is due in great part to the ongoing review, critiques and comments that were received from all the teams' participants.

A description of the teams' areas of focus follows – and we have included a roster of each team with the participants and their affiliations.

Our thanks and appreciation go out to all of these individuals.



Inter-agency Authorization Executive Team – Made up of State officials responsible for policy and funding for the K-12 system and state purchased health care; this team included Cabinet level agencies and certain legislators.

State Agencies

Health Care Authority:	Doug Porter and Heidi Robbins-Brown
Office of Financial Management:	Jim Crawford
Office of Superintendent of Public Instruction:	Ken Kanikeberg
Office of Insurance Commissioner:	Pete Cutler
State Auditor's Office:	Larisa Benson

Legislators

Senate	Karen Keiser, Steve Hobbs, Edward Murray, Randi Becker, Joseph Zarelli
House	Eileen Cody, Ross Hunter, Gary Alexander, Barbara Bailey

Project Leadership and Support Team – Within the Health Care Authority, this group provided executive leadership for the project and was responsible for the report's timely delivery to the State Legislature.

Health Care Authority:	Richard Onizuka, John Williams, Jim Stevenson, Pam Hildebrand
Milliman, Inc.:	Tim Barclay, Lynn Dong
Point B:	Michael Pickett
rialto communications, LLC:	Peter B. Summerville
Camray Consulting, LLC:	Linda Blankenship
Pyramid Communications	Denise Rhiner, Lisa Kagen

Project Design Team – Responsible for developing the design options and project boundaries to be included in the report, this team included Health Care Authority executives and subject matter experts responsible for public employee benefits, pharmacy benefits, health care policy, legal services, fiscal services, actuarial services, and information technology services. A workgroup with expanded participants from an array of Health Care Authority operations functions was formed within the design team to prepare the implementation strategy. The core Health Care Authority design team was also supported by representatives from the Office of Financial Management, Office of the Insurance Commissioner, and Attorney General's Office.

Health Care Authority:	Mary Fliss
	Jason Siems
	Andy Cherullo
	Annette Meyer
	Sharon Michael
	Michael Arnis
	Rich Campbell
Office of Financial Management:	Adam Aaseby
Office of Financial Management:	Paula Moore
Office of Financial Management:	Jason McGill
Office of Financial Management:	Judy Hartmann
Office of the Attorney General:	Melissa Burk-Cain

Implementation Input Teams: Consisted of representatives from school districts, school district brokers, the Washington School Information Processing Cooperative (WSIPC), and Health Care Authority staff of information technology, legal, finance and operations.

K-12 Project Advisory Team – Consisted of education professionals, labor representatives, insurance carriers, school districts, insurance consultants and brokers, and other interested entities. The Advisory Team agreed to serve in a dual role to provide accurate descriptions of the current K-12 employee benefits array and to share their perspectives and expertise to advance the quality and feasibility of a consolidated purchasing system design. The Health Care Authority accepted the participation of Advisory Team members with the understanding that participation did not constitute an endorsement of consolidation or an endorsement of the resultant proposal put forward by the Health Care Authority.

School Officials and Professional Organizations

WA Association of School Administrators/AWSP:	John Kvamme
Washington Association of School Administrators:	Dan Steele
WA State School Directors' Association (Boards):	Debra Long
WA Association of School Business Officials:	Nancy Moffat
WA Association of School Business Officials Sumner SD:	Debbie Campbell
Association of WA School Principals:	Jerry Bender
WA State School Directors' Association (Boards):	Marie Sullivan

Employee Labor Relations

American Federation of Teachers Washington:	Merilee Miron
International Union of Operating Engineers Local 286:	Christian Dube
WA State School Retirees Association:	Ed Gonion
Public School Employees of WA SEIU 1948:	Doug Nelson
WA Education Association:	Randy Parr
Public School Employees of WA SEIU 1948:	Tyler Skillings
Joint Council of Stationary Engineers:	David Westberg

Carriers and Carrier Associations

Group Health Cooperative:	Fred Armstrong, Patty McKeon
Premera Blue Cross:	Lyn Felker, Jae Suzuki, Jim Grazko, Jim Messina
Kaiser Permanente:	Hilary Getz, Elizabeth Engberg, Kay McGinnis, Reine' Morris
Regence Blue Shield:	Jonathan Hensley
ODS Health:	Thad Mick
Washington Association of Health Plans:	Sydney Smith-Zvara

School Districts and Brokers

School District benefits broker (From Sprague Israel Giles):	Sean Corry, Marnie White, Monica Cripe
Everett School Employee Benefit Trust:	David Jonew
Everett Benefit Trust/Everett School District:	Molly Ringo
Spokane Public Schools:	Linda McDermott, Cindy Coleman, Michael Binyon
Seattle Public Schools:	Elaine Williams, Robert Boesche

The Sound Partnership (Tacoma Public Schools):	Michael Peterson
Puget Sound Educational Service District:	Joan Trichtler, Amy Fleming
Auburn School District:	Kelley Nybo
Copperleaf Consultants:	Rich Dickman
Aon Hewitt:	Meg Paul
WA Association of Health Underwriters The Partners Group:	Mark Rose

K-12 Advisory Interested Parties

Group Health Cooperative:	Bob O'Brien
Washington Association of School Administrators:	John Dekker
Alliance of Educational Associations (WASBO):	Mitch Denning
PEB Board Active K-12 Employees Representative:	Phil Karlberg
Washington Education Association / Pacific Public Affairs:	Gary Moore
PEB Board Retired K-12 Employees Representative:	Lee Ann Prielipp
Mercer Consulting:	Sean White
Carney Law/Washington Association of Health Underwriters:	Mel Sorenson

Key Legislators and Legislative Staff – This group offered insight to the project team during organized meetings and individualized discussions.

Senate	Rosemary McAuliffe, Steve Litzow, Curtis King,
House	Kathy Haigh, Chris Reykdal, Bruce Dammeier, Joe Schmick
Senate Staff	Erik Sund, Mich'l Needham, David Hanig, Elise Greef, Susan Mielke, Sydney Forrester Erik Ashlie, Ryan Moore, Kathleen Lawrence
House Staff	David Pringle, Chris Blake, Jane Beyer, Stacey Baker, Ben Rarick, Barbara McLain, Mary Kenfield, Jay Balasbas, Jami Lund, Brian Hardtke

APPENDIX C

13-YEAR HISTORICAL COMPARISON OF THE PEBB PROGRAM STATE ALLOCATION AND K-12 STATE ALLOCATION

School Fiscal Year	PEBB Monthly	K-12 Monthly
SY 2000-01	$426.16	$425.89
SY 2001-02	$457.29	$455.27
SY 2002-03	$482.38	$457.07
SY 2003-04	$504.89	$481.31
SY 2004-05	$584.58	$582.47
SY 2005-06	$663.00	$629.07
SY 2006-07	$684.00	$682.54
SY 2007-08	$707.00	$707.00
SY 2008-09	$561.00	$732.00
SY 2009-10	$745.00	$745.00
SY 2010-11	$850.00	$768.00
SY 2011-12	$850.00	$768.00
SY 2012-13	$850.00	$768.00

^Actual rates for SY 2000-01 to 2010-11. Rates as provided in the enacted 2011-13 budget for SY 2011-12 and SY 2012-13.

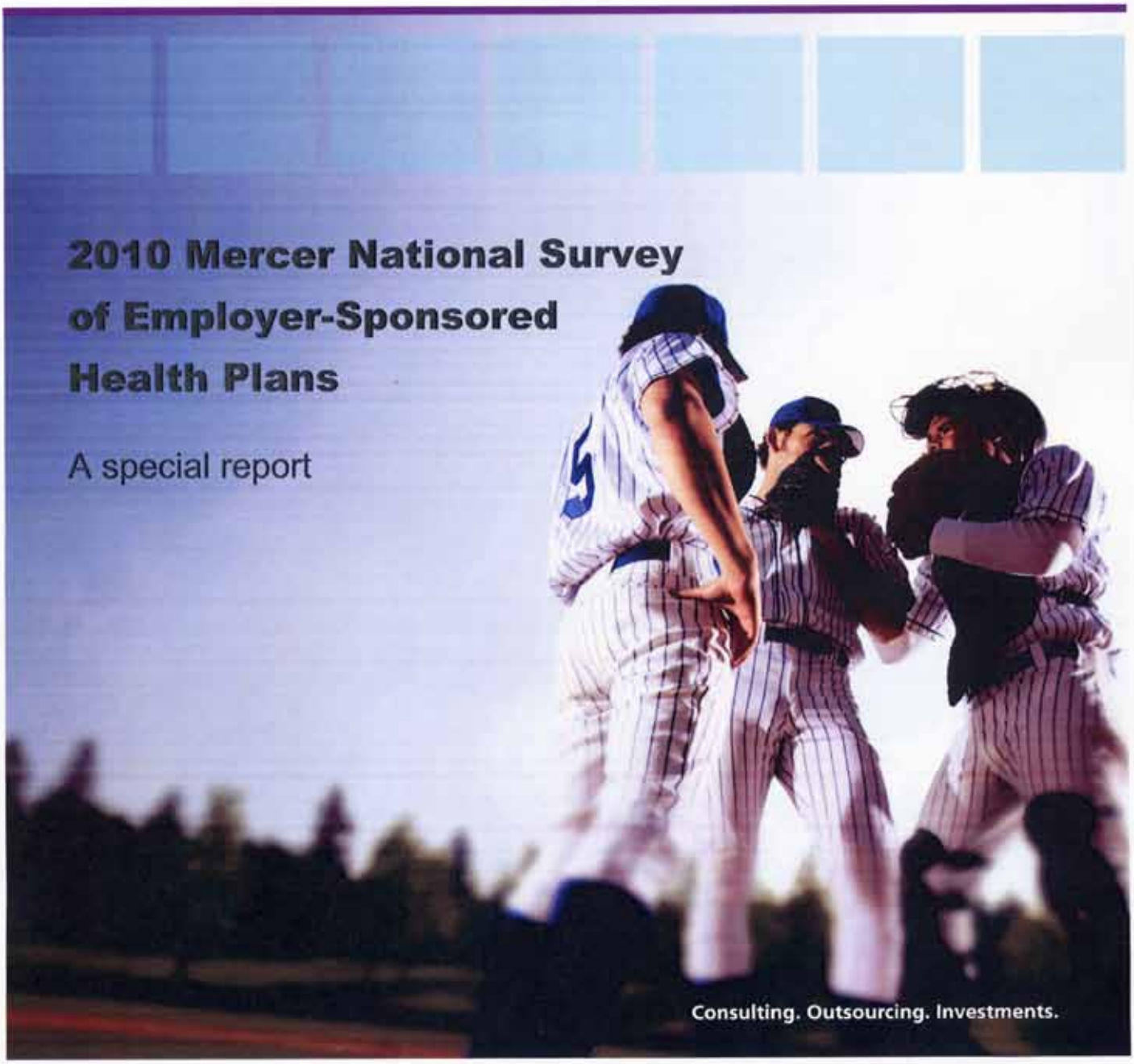
Sources:
K-12 Rates: State Apportionment Reports
http://k12.wa.us/safs/stsm.asp

Program Rates: Health Care Authority

APPENDIX D

MERCER

School Boards and Other Institutions



MERCER

A special report from the

2010 Mercer National Survey of Employer-Sponsored Health Plans

Growth in the average total health benefit cost per employee, which had slowed last year to 5.5%, picked up steam, rising 6.9% to $9,562, the biggest increase since 2004. Employers expect high cost increases again in 2011. They predicted that cost would rise by about 10% if they made no health program changes, with roughly two percentage points of this increase coming solely from changes mandated by health reform for 2011. However, employers expect to hold their actual cost increase to 6.4% by making changes to plan design or changing plan vendors.

Employers did a little of everything to hold down cost increases in 2010. They raised deductibles and dropped HMOs, which were more costly than PPOs. Large employers – especially very large employers – added consumer-directed health plans. Just over half of employers with 20,000 or more employees offered a CDHP in 2010, with 15% of their covered employees enrolled in them. The appeal of these plans is clear: HSA-based CDHP coverage costs almost 25% less than PPO coverage. Employers also took steps to improve workforce health by providing employees with financial incentives to use health management programs or to reward health-conscious behavior.

With health care reform now a reality, employers were asked how likely they are to drop their health plans once state-run insurance exchanges become operational in 2014 and make it easier for individuals to buy coverage. For the great majority, the answer was “not likely.” Large employers remain committed to their role of health plan sponsor, with just 6% of those with 500 or more employees saying they are likely to terminate their health plans. While one-fifth of employers with 10-499 employees say they are likely to drop coverage, this hasn’t happened in Massachusetts, where insurance exchanges have been operating under state-based health reform for over three years.

Using a scientific random sample and supplemental convenience sample, we collected data from 2,833 employers with 10 or more employees. The national and regional results are based on the random sample only and are weighted to be projectable. However, results for city, state and other special employer groups include the convenience sample and are unweighted. In cases where there are too few data to report, "ID" (insufficient data) appears instead of a figure.

NUMBER OF PARTICIPANTS		GEOGRAPHIC REGIONS USED IN THIS SURVEY
School boards and other institutions 500+	117	

Consulting. Outsourcing. Investments.

2010 NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS

	n	School boards and other institutions 500+
NUMBER OF PARTICIPANTS		117

DEMOGRAPHICS

AVERAGE EMPLOYEE AGE	100	42
AVERAGE PERCENT OF FEMALE EMPLOYEES	104	73%
AVERAGE PERCENT OF UNION EMPLOYEES	110	53%
AVERAGE SALARY IN 2009	76	$45,601

HEALTH PLAN PREVALENCE AND ENROLLMENT

PERCENT OF EMPLOYERS OFFERING:		
PREFERRED PROVIDER ORGANIZATIONS (PPO) / POINT-OF-SERVICE (POS) PLANS	117	91%
HEALTH MAINTENANCE ORGANIZATIONS (HMO)		46%
HSA-ELIGIBLE CONSUMER-DIRECTED HEALTH PLANS (CDHPs)		9%
HRA-BASED CDHPs		8%
EITHER TYPE OF CDHP (HSA OR HRA)		17%
TRADITIONAL INDEMNITY PLANS		8%
EMPLOYEE ENROLLMENT:		
PPO / POS	115	68%
HMO		24%
HSA-ELIGIBLE CDHP		2%
HRA-BASED CDHP		4%
EITHER TYPE OF CDHP (HSA OR HRA)		6%
INDEMNITY		2%

ID = INSUFFICIENT DATA. DATA INCLUDED IS NOT PROJECTABLE TO THE ENTIRE POPULATION AND REPRESENTS ONLY THE RESPONDENTS.
2010 MERCER NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS

HEALTH PLAN COST

	n	School boards and other institutions 500+
AVERAGE TOTAL HEALTH BENEFIT COST PER EMPLOYEE:		
ACTIVE EMPLOYEES 2009	61	$9,700
ACTIVE EMPLOYEES 2010		$10,203
PERCENT CHANGE IN COST		5.2%
AVERAGE MEDICAL PLAN COST PER ACTIVE EMPLOYEE:		
PPO / POS 2009	57	$9,156
PPO / POS 2010		$9,532
PERCENT CHANGE IN COST		4.1%
HMO 2009	21	$8,589
HMO 2010		$9,035
PERCENT CHANGE IN COST		5.2%
HSA-ELIGIBLE CDHP 2009[1]	4	ID
HSA-ELIGIBLE CDHP 2010		ID
PERCENT CHANGE IN COST[1]		ID
HRA-BASED CDHP 2009[1]	4	ID
HRA-BASED CDHP 2010		ID
PERCENT CHANGE IN COST[1]		ID
AVERAGE PROJECTED PERCENT CHANGE IN TOTAL HEALTH BENEFIT COST PER EMPLOYEE FOR 2011:		
BEFORE PLAN CHANGES[2]	68	9.8%
AFTER PLAN CHANGES	68	6.9%
AVERAGE TOTAL HEALTH BENEFIT COST AS A PERCENT OF PAYROLL FOR 2009	53	17.2%

[1] 2009 average cost for CDHPs and the % change in cost for CDHPs are not included for any nationally projectable results. Because relatively few employers offer CDHPs, survey results regarding CDHPs have a wider margin of error than for other medical plans, and margin of error is magnified when comparing data across years.

[2] Changes to plan design or health plan vendor. Includes mandatory changes under PPACA.

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2010 MERCER NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS

COVERAGE ELIGIBILITY, ELECTION

	n	School boards and other institutions 500+
COVERAGE FOR NEWLY HIRED FULL-TIME EMPLOYEES BEGINS:		
AT DATE OF HIRE OR FIRST DAY OF THE FOLLOWING MONTH	112	79%
AFTER A WAITING PERIOD		21%
MEDIAN WAITING PERIOD, WHEN REQUIRED (DAYS)	24	30
AVERAGE PERCENT OF EMPLOYEES WHO WAIVE COVERAGE	103	14%
OFFER INCENTIVE TO WAIVE COVERAGE (% OF EMPLOYERS)	117	32%
INCLUDE SPECIAL PROVISIONS CONCERNING COVERAGE FOR SPOUSES WITH OTHER COVERAGE AVAILABLE	113	7%
AVERAGE PERCENT OF EMPLOYEES ELECTING DEPENDENT COVERAGE	97	52%
OFFER SAME-SEX DOMESTIC PARTNER COVERAGE	117	34%
OFFER MINI-MED OR LIMITED HEALTH PLAN	116	3%
OFFER COVERAGE TO PART-TIME EMPLOYEES[1]	112	84%
AVERAGE NUMBER OF HOURS REQUIRED FOR COVERAGE[2]	63	21
COVERAGE FOR NEWLY HIRED PART-TIME EMPLOYEES BEGINS:		
AT DATE OF HIRE OR FIRST DAY OF THE FOLLOWING MONTH	78	78%
AFTER A WAITING PERIOD		22%
MEDIAN WAITING PERIOD, WHEN REQUIRED (DAYS)	16	30
COMPARISON OF BENEFITS FOR FULL-TIME AND PART-TIME EMPLOYEES		
OFFER SAME PLANS, CONTRIBUTIONS ARE THE SAME	81	52%
OFFER SAME PLANS, CONTRIBUTIONS ARE DIFFERENT		44%
OFFER DIFFERENT PLANS		4%
PART-TIME EMPLOYEE CONTRIBUTIONS		
REQUIRE CONTRIBUTION FOR EMPLOYEE-ONLY COVERAGE (% OF EMPLOYERS)	64	92%
AVERAGE CONTRIBUTION AS A PERCENT OF PREMIUM	59	37%
REQUIRE CONTRIBUTION FOR FAMILY COVERAGE (% OF EMPLOYERS)	65	92%
AVERAGE CONTRIBUTION AS A PERCENT OF PREMIUM	60	49%
EMPLOY SEASONAL / TEMPORARY EMPLOYEES WHO MAY WORK 30 OR MORE HOURS PER WEEK:		
YES, AND THEY ARE ELIGIBLE FOR HEALTH BENEFITS	111	9%
YES, BUT THEY ARE NOT ELIGIBLE FOR HEALTH BENEFITS		42%
AVERAGE PERCENT OF TERMINATED EMPLOYEES ENROLLED IN COBRA FROM 7/1/09 - 6/30/10	86	10.3%

[1] Among employers that have part-time employees

[2] Among employers with a minimum hour requirement

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2010 MERCER NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS

EMPLOYEE CONTRIBUTIONS

	n	School boards and other institutions 500+
REQUIRE CONTRIBUTION FOR EMPLOYEE-ONLY COVERAGE (% OF EMPLOYERS)		
PPO / POS	105	82%
HMO	53	79%
HSA-ELIGIBLE CDHP	9	ID
HRA-BASED CDHP	9	ID
AVERAGE MONTHLY CONTRIBUTION AMOUNT FOR EMPLOYEE-ONLY COVERAGE		
PPO / POS	72	$107
HMO	36	$116
HSA-ELIGIBLE CDHP	5	ID
HRA-BASED CDHP	7	ID
AVERAGE CONTRIBUTION AS A % OF PREMIUM FOR EMPLOYEE-ONLY COVERAGE		
PPO / POS	70	23%
HMO	31	26%
HSA-ELIGIBLE CDHP	5	ID
HRA-BASED CDHP	5	ID
REQUIRE CONTRIBUTION FOR FAMILY COVERAGE (% OF EMPLOYERS)		
PPO / POS	104	95%
HMO	53	89%
HSA-ELIGIBLE CDHP	9	ID
HRA-BASED CDHP	9	ID
AVERAGE MONTHLY CONTRIBUTION AMOUNT FOR FAMILY COVERAGE		
PPO / POS	76	$466
HMO	41	$436
HSA-ELIGIBLE CDHP	8	ID
HRA-BASED CDHP	7	ID
AVERAGE CONTRIBUTION AS A % OF PREMIUM FOR FAMILY COVERAGE		
PPO / POS	75	41%
HMO	34	38%
HSA-ELIGIBLE CDHP	8	ID
HRA-BASED CDHP	5	ID
EMPLOYEE CONTRIBUTION RATE TIER STRUCTURE IN LARGEST MEDICAL PLAN		
EMPLOYEE-ONLY, FAMILY (TWO-TIER)	108	24%
EMPLOYEE-ONLY, EMPLOYEE + 1, FAMILY (THREE-TIER)		23%
EMPLOYEE-ONLY, EMPLOYEE + SPOUSE, EMPLOYEE + CHILD(REN), FAMILY (FOUR-TIER PLUS)		40%
OTHER		13%

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2010 MERCER NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS

PPO / POS PLANS

	n	School boards and other institutions 500+
AVERAGE AGE OF ACTIVE EMPLOYEES ENROLLED	88	42
REFERRAL REQUIRED FOR IN-NETWORK SPECIALIST SERVICES	105	11%
INDIVIDUAL DEDUCTIBLE		
REQUIRED FOR IN-NETWORK SERVICES (% OF EMPLOYERS)	104	65%
MEDIAN IN-NETWORK AMOUNT	65	$500
REQUIRED FOR OUT-OF-NETWORK SERVICES (% OF EMPLOYERS)	104	91%
MEDIAN OUT-OF-NETWORK AMOUNT	92	$500
FAMILY DEDUCTIBLE		
REQUIRED FOR IN-NETWORK SERVICES (% OF EMPLOYERS)	103	66%
MEDIAN IN-NETWORK AMOUNT	65	$1,000
REQUIRED FOR OUT-OF-NETWORK SERVICES (% OF EMPLOYERS)	103	92%
MEDIAN OUT-OF-NETWORK AMOUNT	91	$1,000
COST-SHARING FOR IN-NETWORK PHYSICIAN VISIT		
COPAYMENT REQUIRED (% OF EMPLOYERS)	102	80%
COINSURANCE REQUIRED (% OF EMPLOYERS)		17%
NO COST-SHARING FOR IN-NETWORK SERVICES (% OF EMPLOYERS)		7%
MEDIAN COPAYMENT AMOUNT	80	$20
PREVENTIVE CARE COVERAGE		
COVERED AT 100% AND NOT SUBJECT TO COST-SHARING	102	36%
COVERED AT 100% AFTER PRIMARY CARE PHYSICIAN COST-SHARING		22%
COVERED THE SAME AS OTHER BENEFITS (SUBJECT TO DEDUCTIBLE, COPAY / COINSURANCE)		35%
COVERED SOME OTHER WAY		7%
COST-SHARING FOR IN-NETWORK SPECIALIST VISIT		
COPAY HIGHER THAN PRIMARY CARE PHYSICIAN VISIT (% OF EMPLOYERS)	101	38%
MEDIAN COPAY AMOUNT, WHEN HIGHER THAN PHYSICIAN VISIT	36	$35
COST-SHARING FOR OUT-OF-NETWORK PHYSICIAN VISIT		
COPAYMENT REQUIRED (% OF EMPLOYERS)	98	18%
COINSURANCE REQUIRED (% OF EMPLOYERS)		82%
NO COST-SHARING FOR OUT-OF-NETWORK SERVICES (% OF EMPLOYERS)		4%
MEDIAN COINSURANCE AMOUNT (% OF ELIGIBLE EXPENSES)	79	30%
COST-SHARING FOR IN-NETWORK LAB TESTS AND X-RAY / RADIOLOGY SERVICES		
COPAYMENT REQUIRED (% OF EMPLOYERS)	104	29%
COINSURANCE REQUIRED (% OF EMPLOYERS)		39%
NO COST-SHARING FOR IN-NETWORK SERVICES (% OF EMPLOYERS)		36%
MEDIAN COINSURANCE AMOUNT (% OF ELIGIBLE EXPENSES)	41	20%

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2010 MERCER NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS

PPO / POS PLANS, CONTINUED

	n	School boards and other institutions 500+
COST-SHARING FOR OUT-OF-NETWORK LAB TESTS AND X-RAY / RADIOLOGY SERVICES		
COPAYMENT REQUIRED (% OF EMPLOYERS)	103	15%
COINSURANCE REQUIRED (% OF EMPLOYERS)		81%
NO COST-SHARING FOR OUT-OF-NETWORK SERVICES (% OF EMPLOYERS)		10%
MEDIAN COINSURANCE AMOUNT (% OF ELIGIBLE EXPENSES)	81	30%
COST-SHARING FOR IN-NETWORK HOSPITAL STAY		
DEDUCTIBLE / PER-ADMISSION COPAY REQUIRED (% OF EMPLOYERS)	102	18%
COINSURANCE REQUIRED (% OF EMPLOYERS)		56%
NO COST-SHARING FOR IN-NETWORK SERVICES (% OF EMPLOYERS)		26%
MEDIAN DEDUCTIBLE / PER ADMISSION AMOUNT	16	$275
MEDIAN COINSURANCE AMOUNT (% OF ELIGIBLE EXPENSES)	57	20%
COST-SHARING FOR OUT-OF-NETWORK HOSPITAL STAY		
DEDUCTIBLE / PER-ADMISSION COPAY REQUIRED (% OF EMPLOYERS)	98	12%
COINSURANCE REQUIRED (% OF EMPLOYERS)		88%
NO COST-SHARING FOR OUT-OF-NETWORK SERVICES (% OF EMPLOYERS)		3%
MEDIAN DEDUCTIBLE / PER ADMISSION AMOUNT	5	ID
MEDIAN COINSURANCE AMOUNT (% OF ELIGIBLE EXPENSES)	84	30%
COST-SHARING FOR EMERGENCY ROOM VISIT		
SEPARATE COPAY FOR EMERGENCY ROOM VISIT (% OF EMPLOYERS)	100	74%
MEDIAN EMERGENCY ROOM COPAY AMOUNT	71	$100
OUT-OF-POCKET LIMIT FOR INDIVIDUALS		
MEDIAN FOR IN-NETWORK SERVICES	74	$2,000
MEDIAN FOR OUT-OF-NETWORK SERVICES	83	$3,200
FUNDING METHOD		
CONVENTIONALLY INSURED	94	18%
EXPERIENCE-RATED		20%
SELF-FUNDED WITH STOP-LOSS		55%
SELF-FUNDED WITHOUT STOP-LOSS		6%
TYPE OF STOP-LOSS COVERAGE USED		
AGGREGATE STOP-LOSS ONLY	46	17%
SPECIFIC STOP-LOSS ONLY		33%
AGGREGATE AND SPECIFIC STOP-LOSS		50%
AVERAGE COST FOR CLAIMS ADMINISTRATION, PER EMPLOYEE PER MONTH[1]	27	$35

[1] Among self-funded employers that pay a set dollar amount per employee per month

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2010 MERCER NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS

HEALTH MAINTENANCE ORGANIZATIONS

	n	School boards and other institutions 500+
AVERAGE AGE OF ACTIVE EMPLOYEES ENROLLED	41	41
AVERAGE PERCENT OF EMPLOYEES ENROLLED IN HMO, AMONG EMPLOYERS OFFERING HMO(S)	53	52%
COST-SHARING FOR PHYSICIAN VISIT		
COPAY REQUIRED (% OF EMPLOYERS)	52	88%
COINSURANCE REQUIRED (% OF EMPLOYERS)		4%
NO COST-SHARING FOR OFFICE VISIT (% OF EMPLOYERS)		12%
MEDIAN COPAY AMOUNT	45	$20
COST-SHARING FOR SPECIALIST VISIT		
COPAY HIGHER THAN PRIMARY CARE PHYSICIAN VISIT (% OF EMPLOYERS)	51	53%
MEDIAN COPAY AMOUNT, WHEN HIGHER THAN PHYSICIAN VISIT	25	$35
DEDUCTIBLE / PER-ADMISSION COPAY FOR INPATIENT HOSPITAL STAY		
DEDUCTIBLE / PER-ADMISSION COPAY REQUIRED (% OF EMPLOYERS)	52	46%
MEDIAN DEDUCTIBLE / COPAY AMOUNT	22	$250
DEDUCTIBLE / PER-ADMISSION COPAY FOR OUTPATIENT SURGERY		
DEDUCTIBLE / PER-ADMISSION COPAY REQUIRED (% OF EMPLOYERS)	47	28%
MEDIAN DEDUCTIBLE / COPAY AMOUNT	13	$200
DEDUCTIBLE / PER-ADMISSION COPAY FOR EMERGENCY ROOM VISITS		
DEDUCTIBLE / PER-ADMISSION COPAY REQUIRED (% OF EMPLOYERS)	51	75%
MEDIAN DEDUCTIBLE / COPAY AMOUNT	36	$88
FUNDING METHOD (% OF HMOs)		
INSURED -- COMMUNITY-RATED	47	28%
INSURED -- EXPERIENCE-RATED		38%
SELF-FUNDED		33%
OFFER OPEN-ACCESS HMO	51	47%

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2010 MERCER NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS

PRESCRIPTION DRUG BENEFITS[1]

	n	School boards and other institutions 500+
HOW DRUG BENEFITS ARE PROVIDED		
THROUGH A SEPARATE PRESCRIPTION DRUG PLAN (CARVE-OUT)	113	23%
THROUGH THE MEDICAL PLAN, BUT CONSIDERING CARVE-OUT		9%
THROUGH THE MEDICAL PLAN, NOT CONSIDERING CARVE-OUT		68%
% CHANGE IN PRESCRIPTION DRUG COSTS PER EMPLOYEE:		
AT LAST RENEWAL	53	5.3%
EXPECTED AT NEXT RENEWAL	53	4.9%
PARTICIPATE IN A DRUG PURCHASING COALITION / COLLECTIVE	108	10%
RETAIL DRUG COST-SHARING DESIGN USED (% OF EMPLOYERS)		
ONE TIER: SAME COST-SHARING FOR ALL DRUGS	108	0%
TWO TIERS: GENERIC / BRAND DRUGS		18%
THREE TIERS: GENERIC / BRAND FORMULARY / BRAND NON-FORMULARY		69%
FOUR OR FIVE TIERS: INCLUDES SEPARATE PAYMENTS FOR SPECIALTY / BIOTECH OR LIFESTYLE DRUGS		10%
USE COINSURANCE FOR RETAIL DRUGS IN ONE OR MORE CATEGORIES (% OF EMPLOYERS)	101	7%
AVERAGE COPAYS FOR RETAIL DRUGS IN PLANS WITH THREE-TIER DESIGN		
GENERIC	72	$11
BRAND-NAME FORMULARY	72	$28
BRAND-NAME NON-FORMULARY	65	$44
OFFER PRESCRIPTION DRUG MAIL-ORDER PLAN	113	93%
MAIL-ORDER PLAN COST-SHARING DESIGN USED (% OF EMPLOYERS)		
ONE TIER: SAME PAYMENT FOR ALL DRUGS	100	5%
TWO TIERS: GENERIC / BRAND DRUGS		17%
THREE TIERS: GENERIC / BRAND FORMULARY / BRAND NON-FORMULARY		66%
FOUR OR FIVE TIERS: INCLUDES SEPARATE PAYMENTS FOR SPECIALTY / BIOTECH OR LIFESTYLE DRUGS		10%
USE COINSURANCE IN MAIL-ORDER PLAN FOR ONE OR MORE DRUG CATEGORIES (% OF EMPLOYERS)	90	8%
AVERAGE COPAYS FOR MAIL-ORDER DRUGS IN PLANS WITH THREE-TIER DESIGN		
GENERIC	60	$17
BRAND-NAME FORMULARY	63	$46
BRAND-NAME NON-FORMULARY	57	$78

[1] Offered to employees enrolled in the largest medical plan of any type

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2010 MERCER NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS

PRESCRIPTION DRUG BENEFITS, CONTINUED

	n	School boards and other institutions 500+
FEATURES OF PRESCRIPTION DRUG PLANS[1]		
MANDATORY GENERICS (DAW 1&2)	71	27%
MANDATORY GENERICS WITH PHYSICIAN OVERRIDE (DAW 2)		37%
MANDATORY MAIL-ORDER		14%
RETAIL PENALTY PROGRAM (MAINTENANCE DRUGS ARE SUBJECT TO HIGHER COST SHARING AFTER 2-4 FILLS AT A RETAIL PHARMACY)		15%
PROGRAM TO EDUCATE PHYSICIANS / MEMBERS ON GAPS IN CARE, USING MEDICAL AND PHARMACY DATA		13%
PROMOTE THE USE OF OTC ALTERNATIVES WITH HIGHER COST SHARE OR BENEFIT EXCLUSION FOR SELECT CATEGORIES OF DRUGS		15%

HEALTH MANAGEMENT PROGRAMS[2]

DISEASE MANAGEMENT PROGRAMS OFFERED		
ASTHMA / COPD	110	61%
CANCER		53%
CONGESTIVE HEART FAILURE (CHF)		58%
CORONARY ARTERY DISEASE (CAD)		56%
DEPRESSION		51%
DIABETES		67%
HYPERTENSION		48%
LOW-BACK PAIN		32%
OBESITY		34%
RARE DISEASES		29%
ANY DISEASE MANAGEMENT PROGRAM(S)		77%
OTHER HEALTH MANAGEMENT PROGRAMS OFFERED		
BEHAVIOR MODIFICATION	97	53%
CASE MANAGEMENT	100	73%
END-OF-LIFE CASE MANAGEMENT	87	55%
HEALTH ADVOCATE SERVICES	92	57%
HEALTH RISK ASSESSMENT (HRA)	103	56%
HEALTH WEBSITE	107	92%
NURSE ADVICE LINE	104	81%
DISEASE OR HEALTH MANAGEMENT PROGRAMS ARE PROVIDED:		
THROUGH THE HEALTH PLAN -- STANDARD SERVICES ONLY	104	70%
THROUGH THE HEALTH PLAN -- SOME OPTIONAL SERVICES		33%
THROUGH ONE OR MORE SPECIALTY VENDOR(S)		14%
AVERAGE EMPLOYEE PARTICIPATION RATE FOR MOST RECENT COMPLETE PROGRAM YEAR		
COMPLETED HEALTH RISK ASSESSMENT (% ELIGIBLE EMPLOYEES)	34	22%
ACTIVELY ENGAGED IN ANY DISEASE MANAGEMENT PROGRAM (% IDENTIFIED PERSONS)	19	17%
ACTIVELY ENGAGED IN ANY BEHAVIOR MODIFICATION PROGRAM (% IDENTIFIED PERSONS)	14	12%

[1] Based on employers with 1,000 or more employees

[2] Offered to employees enrolled in the largest medical plan of any type

ID = INSUFFICIENT DATA. DATA INCLUDED IS NOT PROJECTABLE TO THE ENTIRE POPULATION AND REPRESENTS ONLY THE RESPONDENTS.
2010 MERCER NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS

HEALTH MANAGEMENT PROGRAMS, CONTINUED

	n	School boards and other institutions 500+
USE INCENTIVES OR PENALTIES TO ENCOURAGE PARTICIPATION IN ANY HEALTH MANAGEMENT PROGRAM	**105**	**27%**
AMONG EMPLOYERS OFFERING PROGRAM, PERCENT USING INCENTIVE TO ENCOURAGE PARTICIPATION IN:		
HEALTH RISK ASSESSMENT	**56**	**36%**
DISEASE MANAGEMENT	**76**	**11%**
TARGETED BEHAVIOR MODIFICATION	**49**	**14%**
TYPE OF HRA INCENTIVES USED (AMONG EMPLOYERS OFFERING HRA INCENTIVE)		
CASH / GIFT CARDS	**20**	**65%**
FINANCIAL CONTRIBUTION TO AN HRA, HSA OR FSA		**5%**
LOWER PREMIUM CONTRIBUTIONS		**25%**
HAVE ATTEMPTED TO MEASURE RETURN ON INVESTMENT (ROI) FOR DISEASE OR HEALTH MANAGEMENT PROGRAMS OFFERED	**98**	**21%**
OF THOSE, PERCENT SATISFIED WITH ROI	**21**	**57%**

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2010 MERCER NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS

DENTAL COVERAGE

	n	School boards and other institutions 500+
OFFER DENTAL COVERAGE	**114**	**96%**
HOW DENTAL IS PROVIDED		
THROUGH FREESTANDING PLAN	109	84%
AS PART OF MEDICAL PLAN		17%
AVERAGE DENTAL COST PER EMPLOYEE		
2009	46	$777
2010		$809
PERCENT CHANGE IN COST		4.1%
EMPLOYEE CONTRIBUTION FOR DENTAL COVERAGE – EMPLOYEE-ONLY		
REQUIRE CONTRIBUTION (% OF EMPLOYERS)	78	64%
AVERAGE MONTHLY CONTRIBUTION AMOUNT	36	$21
AVERAGE CONTRIBUTION AS A PERCENT OF PREMIUM	42	65%
EMPLOYEE CONTRIBUTION FOR DENTAL COVERAGE – FAMILY		
REQUIRE CONTRIBUTION (% OF EMPLOYERS)	81	74%
AVERAGE MONTHLY CONTRIBUTION AMOUNT	48	$64
AVERAGE CONTRIBUTION AS A PERCENT OF PREMIUM	48	70%
TYPE OF DENTAL PLAN OFFERED		
ACTIVE PPO	105	51%
PASSIVE PPO		32%
DENTAL HMO		21%
DISCOUNT CARD		6%
SERVICES COVERED BY DENTAL PLAN		
SEALANTS	101	73%
IMPLANTS		43%
ADULT ORTHODONTICS		39%
TREATMENT OF TMJ		24%
POSTERIOR COMPOSITES		40%
DENTAL PLAN DEDUCTIBLE REQUIRED[1] (% OF EMPLOYERS)	101	65%
MEDIAN DOLLAR AMOUNT	61	$50
DENTAL PLAN INCLUDES ANNUAL MAXIMUM BENEFIT[1] (% OF EMPLOYERS)	101	81%
MEDIAN DOLLAR AMOUNT	78	$1,500
DENTAL PLAN INCLUDES LIFETIME MAXIMUM BENEFIT FOR ORTHODONTIC SERVICES[1] (% OF EMPLOYERS)	88	80%
MEDIAN DOLLAR AMOUNT	67	$1,200

[1] Among employers with dental PPOs or fee-for-service plans

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2010 MERCER NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS

OTHER BENEFITS

	n	School boards and other institutions 500+
VOLUNTARY INSURANCE BENEFITS OFFERED		
VISION	109	72%
DISABILITY		83%
ACCIDENT		42%
WHOLE / UNIVERSAL LIFE		51%
CANCER / CRITICAL ILLNESS		59%
HOSPITAL INDEMNITY		24%
LONG-TERM CARE		41%
AUTO / HOMEOWNERS		9%
TRAVEL		9%
VOLUNTARY BENEFITS AND CORE BENEFITS INTEGRATED ON SAME ADMINISTRATION PLATFORM	93	48%
ACTIONS PLANNED OVER THE NEXT 3-5 YEARS WITH REGARD TO VOLUNTARY BENEFITS		
ADD ONE OR MORE VOLUNTARY BENEFIT OFFERINGS	107	33%
TRANSITION ONE OR MORE EMPLOYER-PAID BENEFITS TO EMPLOYEE-PAID (FULLY OR PARTIALLY)		8%
DROP CURRENT VOLUNTARY BENEFIT OFFERINGS		2%
WORK-LIFE BENEFITS OFFERED[1]		
FITNESS CENTER DISCOUNTS	107	51%
RELOCATION ASSISTANCE		7%
LEGAL CONSULTATION AND REFERRAL		27%
FINANCIAL CONSULTATION AND REFERRAL		23%
ON-SITE OR NEAR-SITE DEPENDENT CARE (OR SUBSIDY)		8%
DEPENDENT CARE RESOURCE AND REFERRAL		14%
ELDER CARE RESOURCE AND REFERRAL		15%
ADOPTION ASSISTANCE		4%
SCHOOL / COLLEGE LOCATOR SERVICE		6%
TELECOMMUTING / WORK-FROM-HOME POLICY		5%
HEALTH CARE SPENDING ACCOUNT		
OFFER ACCOUNT (% OF EMPLOYERS)	112	79%
AVERAGE PERCENT OF ELIGIBLE EMPLOYEES PARTICIPATING	71	24%
AVERAGE ANNUAL VOLUNTARY CONTRIBUTION	55	$1,336
DEPENDENT CARE SPENDING ACCOUNT		
OFFER ACCOUNT (% OF EMPLOYERS)	112	79%
AVERAGE PERCENT OF ELIGIBLE EMPLOYEES PARTICIPATING	68	13%
AVERAGE ANNUAL VOLUNTARY CONTRIBUTION	57	$3,158

[1] Based on employers with 500 or more employees

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2010 MERCER NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS

DEFINITIONS

HEALTH PLAN PREVALENCE AND ENROLLMENT

A **consumer-directed health plan eligible for a Health Savings Account** is a high-deductible health plan with an employee-controlled account. Employer contributions are optional. Account funds roll over at year end and are portable.

A **consumer-directed health plan with a Health Reimbursement Account** is a health plan with an employer-funded spending account. Account funds may roll over at year end, but are not portable.

HEALTH PLAN COST

Total health benefit cost is the total gross cost for all medical, dental, prescription drug, MH / SA, vision and hearing benefits for all covered active employees and their dependents divided by the number of enrolled employees. Total gross annual cost includes employee contributions but not employee out-of-pocket expenses.

Medical plan cost is the total gross cost for medical plans divided by the number of enrolled employees. Prescription drug, mental health, vision and hearing benefits for all active employees and their covered dependents are included if part of the plan. Dental benefits, even if a part of the plan, are not included in these costs.

COVERAGE ELIGIBILITY, ELECTION

A **mini-med or limited plan** is a health insurance plan that provides far lower benefits than the typical comprehensive major medical plan. The annual maximum amount payable typically ranges from $1,000 to $50,000.

EMPLOYEE CONTRIBUTIONS, PPO/POS, CDHP, DENTAL

Family coverage is the coverage level for an employee, spouse and two children.

HEALTH REFORM

The **2011 PPACA requirements** include coverage for children up to age 26 and the elimination of lifetime and most annual maximums.

PPACA's **"shared responsibility"** provision will require employers to provide coverage to employees working on average 30 or more hours per week in a month, or else face penalties, starting in 2014.

Under PPACA's **affordable coverage** provision, employers must offer at least one health plan for which the employee's premium contribution does not exceed 9.5% of the employee's household income or else be subject to penalties.

Starting in 2018, health benefit coverage that costs more than $10,200 for an individual employee or $27,500 for dependent coverage will be subject to a 40% **excise tax**.

SPECIAL COVERAGES

The federal 2008 **Mental Health Parity and Addiction Equity Act** requires that if mental health and substance abuse benefits are offered that they provide the same level of coverage as the medical benefit.

RETIREE HEALTH CARE

Under the **Early Retiree Reinsurance Program**, the federal government will reimburse up to 80% of claims between $15,000 and $90,000 for each non-Medicare-eligible retiree age 55 or older and his or her dependents, for plan years ending after June 1, 2010.

2010 NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS
LIST OF PARTICIPATING EMPLOYERS

School boards and other institutions 500+
ACADEMY SCHOOL DISTRICT TWENTY
ALDINE INDEPENDENT SCHOOL DISTRICT
AMERICAN UNIVERSITY
ANNE ANNDEL COUNTY PUBLIC SCHOOLS
BALTIMORE COUNTY PUBLIC SCHOOLS
BARBERS HILL INDEP SCH DIST
BEAUREGARD PARISH SCHOOL DST
BEMIDJI IND SCHOOL DISTRICT 31
BLOOMINGTON PUBLIC SCHOOLS, DISTRICT 87
BLYTHEVILLE SCHOOL DISTRICT 5
BOARD OF EDUCATION OF
BRIGHT HORIZONS FAMILY SOLUTIONS INC.
CADDO PARISH SCHOOL BOARD
CARROLL INDEPENDENT SCHOOL DST
CENTRAL DAUPHIN SCHOOL DST
CHARLES COUNTY PUBLIC SCHOOL
CITY OF RICHMOND PUBLIC SCHOOLS
COLORADO SPRINGS SCHOOL DISTRICT NO 11
CONSOLIDATED SCHOOL DST NO2
CORPUS CHRISTI IND SCHL DST
CYPRESS-FAIRBANKS ISD
DALLAS INDEPENDENT SCHOOL DST
DELTA COUNTY JOINT SCHOOL DIST 50J
DUVAL COUNTY PUBLIC SCHOOLS
EAGLE COUNTY SCHL DST RE-50 J
EAST BATON ROUGE PARISH SCHOOL SYSTEM
EAST STROUDSBURG AREA SCHL DST
ELKO COUNTY SCHOOL DISTRICT
EVESHAM TOWNSHIP BOARD EDUCATN
FREMONT COUNTY SCHL DST NO 25
GARFIELD SCHOOL DST NO RE-2
GLOUCESTER COUNTY SCHOOL BOARD
GRANTS CIBOLA COUNTY SCHL DST
GREAT FALLS PUBLIC SCHL DST 1
HENDERSON COUNTY BOARD OF EDUCATION
HOUSTON INDEPENDENT SCHOOL DISTRICT
INDEPENDENT SCHOOL DST 279
INDEPENDENT SCHOOL DST 624
INDIAN RIVER SCHOOL DISTRICT
JOHNSON CITY GOVT SD
KAMEHAMEHA SCHOOLS
KATY INDEPENDENT SCHOOL DISTRICT
KILLEEN INDEPENDENT SCHOOL DST
KLEIN INDEPENDENT SCHOOL DISTRICT
LAKE CENTRAL SCHOOL CORP
LANCASTER CENTRAL SCHOOLS
LIVONIA PUBLIC SCHOOL DISTRICT
LONG BEACH UNIFIED SCHOOL DIST

LOS ANGELES UNIFIED SCHL DIST
LOVETT SCHOOL
MARSHALLTOWN CMNTY SCHL DST
METROPLTAN NSHVLLE PUB SCHOOLS
MIDDLE COUNTRY CENTL SCHL DST
MOLINE SCHOOL DISTRICT
MT HEALTHY BOARD OF EDUCATION
MUSTANG PUBLIC SCHOOLS
NEW CASTLE COMMUNITY SCHOOL
NEWARK CEBSCHOOL DISTRICT
NEWARK CITY SCHOOLS
NORFOLK PUBLIC SCHOOLS
NORTH EAST INDEPENDENT SCHOOL DISTRICT
NORTH PUBLIC SCHOOL
NORTHPORT-EAST NORTHPORT UNION
NORTHSIDE INDEPENDENT SCHL DST
NYE COUNTY SCHOOL DISTRICT
OAK HILLS LOCAL SCHOOL DST
ORANGE COUNTY PUBLIC SCHL DST
OREGON CITY SCHOOL DISTRICT
PARMA CITY SCHOOL DISTRICT
PASSAIC BD TECH & VOCT EDUCATN
PHILADELPHIA SCHOOL DISTRICT
PHILLIPS EXETER ACADEMY
PITTSBURGH BOARD OF EDUCATION
PITTSYLVANIA COUNTY SCHOOL BD
PLACENTIA-YORBA LINDA UNIFIED SCHOOL DIS
PORT CHESTER-RYE UNION FREE
PRINCE WILLIAM COUNTY SCHOOLS
PRINCETON REGIONAL SCHOOL DST
PRINCETON REVIEW
PUTNAM COUNTY BOARD EDUCATION
RASMUSSEN COLLEGE -ST CLOUD
REORGANIZED SCHOOL DISTRICT 7
ROCKLIN UNIFIED SCHOOL DST
SABINE PARISH SCHOOL DISTRICT
SACRAMENTO CY UNIFIED SCHL DST
SAN ANGELO IND SCHL DST
SANGER UNIFIED SCHOOL DISTRICT
SCHOOL BOARD OF THE CITY OF NORFOLK OLK
SCHOOL BOARD PALM BEACH COUNTY
SCHOOL BOARD PINELLAS CNTY FLA
SCHOOL DIST OF ESCAMBIA COUNTY
SCHOOL DISTRICT 6
SCHOOL DISTRICT FREMONT RE 1
SCHOOL DISTRICT KETTLE MORAINE
SCHOOL DISTRICT OF MILTON
SCHOOL DST OF HRNANDO CNTY FLA
SHELBY COUNTY BOARD EDUCATION
SIMI VALLEY UNIFIED SCHOOL DST
SNOHOMISH SCHOOL DISTRICT
SOUTH SANPETE SCHOOL DISTRICT

ST JAMES PARISH SCHOOL BOARD
SUPERVISORY UNION 12
THREE RIVERS SCHOOL DISTRICT
TOLEDO PUBLIC SCHOOLS
TWIN RIVERS UNIFIED SCHOOL DST
UNIFIED SCHOOL DISTRICT 259
UNIFIED SCHOOL DISTRICT 457
VERONA AREA SCHOOL DISTRICT
VIRGINIA BEACH CITY & SCHOOLS
WALLED LAKE CNSLD SCHL DST
WARREN COUNTY PUBLIC SCHOOLS
WARREN COUNTY SCHOOL DISTRICT
WAUSAU SCHOOL DISTRICT
WETHERSFIELD BOARD EDUCATION
WILLOGHBY EASTLAKE CY SCHL DST
WORTHINGTON CITY SCHOOL DST
YONKERS CITY SCHOOL DISTRICT

APPENDIX E

TOWERS WATSON

Memo

To: Joan Kapowich (OEBB) Date: February 3, 2011

From: Steve Carlson, F.S.A. (Towers Watson)

Subject: **OEBB Benefits Program Savings**

The purpose of this summary is to share with interested parties the estimated benefit plan premium savings which OEBB has achieved in the first three years of its operation, as well as to provide some historical background and a summary of key assumptions used in estimating these savings. The first section of this memo covers the savings associated with the health benefits, and the second section, the optional benefits.

MEDICAL, PHARMACY, DENTAL, AND VISION BENEFITS

Background

During the 2007 legislative session the potential savings from a statewide educators benefit pool was estimated to be five percent, or $40 million a year, primarily due to savings in administrative costs. Administrative costs are embedded in premium costs and cover the expenses of plan administration, such as plan set-up, account management, network contracting, claims payment, and customer service. OEBB streamlined the number of medical plan designs offered in the state from 88 to nine. This is one example of efficiencies in administration that yield savings in a benefit pool arrangement.

After the OEBB program was designed and launched, as your actuary, Towers Watson (then Watson Wyatt) prepared an estimate of the first-year (2008/2009 plan year) savings based on the actual OEBB premium rates and enrollment as of October 1, 2008, for the Medical, Pharmacy, Dental and Vision benefits. The estimated savings was $36 million, or 5.8%, based on enrollment of approximately 49,000 active employees (and their family members). These results were posted during the 2009 legislative session.

Summary of Savings Achieved

Now that the program has been in place for over two full years, we have done a further evaluation of the savings achieved by the OEBB program. This evaluation has included a re-evaluation of the first year savings, as well as estimates of savings achieved in the two subsequent years. For the Medical, Pharmacy, Dental, and Vision benefits, the estimated savings achieved on behalf of active employees (and their family members) is as follows:

2008/2009: $39.6 million

2009/2010: $40.1 million

2010/2011: $45.6 million

Some additional detail is provided in the attached exhibit. Additional savings for current retirees and COBRA beneficiaries, and potential future OEBB enrollees, have not been calculated.

Assumptions

The following is a brief summary of important assumptions used in developing the savings estimates:

- Savings is defined as the difference between actual premiums paid to OEBB by participants for benefit plans (A) minus the projected premiums those participants would have paid if OEBB had not been created (P).
- The projected premiums (P) are based on the actual premiums participants were paying in the 2007/2008 plan year (as reported in the survey of educational entities which OEBB conducted during the 2007/2008 plan year), inflated with an average trend taken from an annual Oregon statewide insurance carrier cost trend survey. In the first year, for some participants, a 2008/2009 pre-OEBB premium rate was available and where possible we have used those actual figures instead of projections based on the trend survey. In addition, not all OEBB participating entities (districts, educational service districts, and community colleges) provided their historical information (enrollment, plan design, and premium rates) for the 2007/2008 year when OEBB conducted the survey. This means that the pre-OEBB costs used in these savings calculations represent the costs for a participant group which is substantially similar to the actual OEBB participants, but not identical. In years two and three, we used the trend survey in all cases as actual figures were not available.
- In order to ensure a comparison of premiums for comparable plans, we have used the actual enrollment for each of the three years as a basis for both the actual OEBB premium cost (A) and the projected cost (P).

Other Issues and Considerations

Calculating cost savings from the implementation of OEBB is complicated by a few important factors which we have outlined here.

First, plan design choices are not static. That is, school districts and employees have some choice of plan, and are not necessarily required to select an OEBB plan which is similar in value to their pre-OEBB plan. In fact, we know from reviewing enrollment statistics that a significant number of plan participants "opted up" to a more generous plan of benefits in the first year of OEBB.

Second, and related to the first issue, as the OEBB Board has seen in periodic reports we have provided, OEBB plan utilization levels are significantly above the norm, and it now seems clear that this enrollment pattern of "opting up" is one contributing factor to these higher utilization levels.

Third, the October 1, 2008 effective date for OEBB coincided with perhaps the most significant economic downturn in half a century. It is a well-documented underwriting phenomenon that in deteriorating economic conditions, health insurance utilization rises as members respond to the overall anxiety and uncertainty in their lives as well as the potential that they may lose access to their job-related insurance benefits. In the last two years this has been observed not only for OEBB but across the U.S.

Outlook

While factors two and three above had no impact on *first-year* OEBB premium rates, actual experience is an important factor in subsequent OEBB renewals. This has had two important implications: OEBB has been challenged with higher-than-planned-for premium rate increases in years two and three, and the Board has had extra motivation to address this utilization in establishing health and wellness related programs, value-based plan designs, and other key initiatives to promote good health and appropriate care and provide participants with the best program value in the future. This is the "future promise" of OEBB which has been outlined as far back as the testimony in legislative session before OEBB-enabling legislation was originally passed.

OPTIONAL BENEFITS (LIFE, DISABILITY, AND AD&D INSURANCE)

Savings

In addition to the savings described above, OEBB has realized significant premium savings associated with the optional benefits, which took effect in October 2009. We estimate the following savings has been achieved:

2009/2010: $5.3 million or 36%

2010/2011: $6.4 million or 36%

Assumptions

The following is a brief summary of important assumptions used in developing the savings estimates:

- Savings is defined as the difference between actual premiums paid to OEBB by participants for benefit plans (A) minus the projected premiums those participants would have paid if OEBB had not been created (P).
- In order to ensure a comparison of premiums for comparable plans, we have used the actual enrollment for each of the two years as a basis for both the actual OEBB premium cost (A) and the projected cost (P).

Other Issues and Considerations

Calculating cost savings from the implementation of optional benefits by OEBB is somewhat complicated by the fact that school districts and employees are not necessarily required to select an OEBB plan which is similar in value to their pre-OEBB plan. In fact, for many school districts, the OEBB offerings presented the opportunity to offer new or different benefits to employees for the first time. In these situations, where there was not pre-OEBB coverage, we have based our savings estimate on the average rates paid by others for such coverage pre-OEBB.

Outlook

Enrollment in the optional benefits increased significantly in the most recent year. We expect this will continue in future years as members become more familiar with the coverage options and the favorable pricing available.

OEBB
Medical, Pharmacy, Dental, Vision and Optional Benefits Plan Savings

2008-2009 Plan Year

	Pre-OEBB Plans	OEBB Plans
Medical/Rx	$547,000,000	$509,500,000
Dental	$68,600,000	$65,800,000
Vision	$12,000,000	$12,700,000
Optional Benefits	n/a	n/a
Total	$627,600,000	$588,000,000
Estimated Savings		
Dollar		-$39,600,000
Percent		-6.3%

2009-2010 Plan Year

	Pre-OEBB Plans	OEBB Plans
Medical/Rx	$589,400,000	$549,300,000
Dental	$70,800,000	$69,200,000
Vision	$11,800,000	$13,400,000
Optional Benefits	$14,900,000	$9,600,000
Total	$686,900,000	$641,500,000
Estimated Savings		
Dollar		-$45,400,000
Percent		-6.6%

2010-2011 Plan Year

	Pre-OEBB Plans	OEBB Plans
Medical/Rx	$616,400,000	$571,700,000
Dental	$73,400,000	$70,300,000
Vision	$11,900,000	$14,100,000
Optional Benefits	$17,700,000	$11,300,000
Total	$719,400,000	$667,400,000
Estimated Savings		
Dollar		-$52,000,000
Percent		-7.2%

APPENDIX F

INVENTORY OF STATUTES AFFECTING K-12 EMPLOYEE HEALTH BENEFITS AND HEALTH CARE AUTHORITY RESPONSIBILITIES

RCW 28A.400.200 – http://apps.leg.wa.gov/rcw/default.aspx?cite=28A.400.200

RCW 28A.400.270 – http://apps.leg.wa.gov/rcw/default.aspx?cite=28A.400.270

RCW 28A.400.275 – http://apps.leg.wa.gov/rcw/default.aspx?cite=28A.400.275

RCW 28A.400.280 – http://apps.leg.wa.gov/rcw/default.aspx?cite=28A.400.280

RCW 28A.400.350 – http://apps.leg.wa.gov/rcw/default.aspx?cite=28A.400.350

RCW 41.05.008 – http://apps.leg.wa.gov/rcw/default.aspx?cite=41.05.08

RCW 41.05.009 – http://apps.leg.wa.gov/rcw/default.aspx?cite=41.05.09

RCW 41.05.011 – http://apps.leg.wa.gov/rcw/default.aspx?cite=41.05.011

RCW 41.05.021 – http://apps.leg.wa.gov/rcw/default.aspx?cite=41.05.021

RCW 41.05.022 – http://apps.leg.wa.gov/rcw/default.aspx?cite=41.05.022

RCW 41.05.050 – http://apps.leg.wa.gov/rcw/default.aspx?cite=41.05.050

RCW 41.05.055 – http://apps.leg.wa.gov/rcw/default.aspx?cite=41.05.055

RCW 41.05.065 – http://apps.leg.wa.gov/rcw/default.aspx?cite=41.05.065

RCW 41.05.080 – http://apps.leg.wa.gov/rcw/default.aspx?cite=41.05.080

RCW 41.05.085 – http://apps.leg.wa.gov/rcw/default.aspx?cite=41.05.085

RCW 41.56 – http://apps.leg.wa.gov/rcw/default.aspx?cite=41.56

RCW 41.59 – http://apps.leg.wa.gov/rcw/default.aspx?cite=41.59

RCW 48.62 – http://apps.leg.wa.gov/rcw/default.aspx?cite=48.62.071

APPENDIX G

THE K-12 PUBLIC SCHOOL EMPLOYEE HEALTH BENEFITS REPORT

PROJECT TERMINOLOGY

KEY PROJECT TERMS

The K-12 Public School Employees' Health Benefits Report — The name of the report, which the Health Care Authority has been tasked with writing by the Legislature, outlining a proposed purchasing strategy for a strengthened, consolidated public school employee health benefits system.

The K-12 Public School Employees' Health Benefits Report project — The name of the overarching project to produce the report.

K-12 public school employees' health benefits purchasing system — The system by which K-12 public school employees obtain health benefits.

Project Teams — The five established teams of participants and stakeholders involved in the project:

Project Leadership and Support Team
Project Design Team
Inter-agency Authorization Executive Team
K-12 Project Advisory Team
Key Legislators and Staff

See the full roster or project committee diagram for more details on each committee—available on the project website: http://www.hca.wa.gov/k12report

State Auditor's Office Performance Review of K-12 Employee Health Benefits, which includes the HayGroup study — How we refer to the combined State Auditor's Office report and HayGroup study; note: this performance review was delivered to the Legislature in February 2011.

GLOSSARY OF INDUSTRY TERMS

Actuarial Value — A method for measuring the value to an average enrollee of the benefits provided by a health benefits plan. It represents the average percentage of allowed medical costs that would be paid by the plan, assuming a specified standard enrollee population. It does not include premium costs, and represents an average value; the percentage payout for any particular enrollee may be very different from the actuarial value of a plan.

Adverse Selection (Anti-Selection) — The tendency of individuals with a higher probability of incurring claims (high risk) to select the maximum amount of insurance protection, while those with lower probability elect lower levels of, or defer, coverage.

Carve-Out — Removing a specific benefit from the contract with the primary health plan and negotiating the coverage separately, usually with a specialty vendor or network. For instance, prescription drug coverage is often purchased separately on a self-funded basis from a specialized pharmacy benefit manager. It should not be confused with the term "carveout" (defined below) which is sometimes used to describe the Washington State retiree remittance.

Case Management — A process which focuses on coordinating a number of services required by severely ill or injured participants to ensure that provided services are appropriate, timely, thorough yet non-redundant and cost effective.

COBRA — Combined Omnibus Budget Reconciliation Act of 1985

Coinsurance — A common provision of health care plans in which the covered individual and the insurer or plan sponsor share in a specified ratio of health care expenses (e.g., 80% paid by plan, 20% paid by participant). In a PPO or POS plan, the ratio usually favors the covered individual when the costs are incurred with providers who are part of the PPO or part of a specified network (e.g., 100% coverage within the PPO or network and 70% coinsurance ratio for providers outside the PPO or network).

Consolidated Health Benefits Purchasing System – Currently, the 300+ public school districts purchase employee health benefits through scores of health benefit plans. The State Legislature tasked the Health Care Authority to recommend a single purchasing system to be administered by the State that would establish statewide standards and practices for health insurance plan offerings.

Contributory Benefit Plan — A program in which the employee contributes part (or all) of the cost, and the employer covers any remainder.

Co-Payments — Payments that are required to be made by covered participants on a per service basis (e.g.; $20 co-pay per physician visit). Co-payments are commonly used to discourage inappropriate utilization and to help finance health care plans.

Cost Savings — As described in the Report, cost savings are related to administrative simplification and result in future avoided expenses that are subsequently reflected in lower premiums and district administrative budgets.

Deductible — The amount paid by an employee for covered expenses in a group health plan before the plan pays benefits. A typical plan would follow a calendar year schedule and specify an individual deductible and a higher family deductible.

Disease Management (DM) — Disease management refers to the process of identifying health plan enrollees with particular health conditions or risk factors, then assisting those enrollees in managing their conditions to delay the onset or slow the progression of disease.

Equity — Is related to consistent and uniform application of purchasing policy in a number of areas to afford employees access to affordable health benefits, e.g. subsidy dollars, employee eligibility, employee premium sharing, and common benefit plan portfolios.

ESD — Educational Service Districts are regional administrative units created by statute that evolved from county superintendents. There are currently nine ESDs in Washington.

Experience Rating — A premium based on the anticipated claims experience of, or utilization of service, by a contract group according to its age, sex, and any other attributes expected to affect its health service utilization. Such a premium is subject to periodic adjustment, generally on an annual basis, in line with actual claims or utilization experience.

FTE — Full Time Equivalent (FTE) is a unit to measure employed persons in a way that makes them comparable although they may work a different number of hours per week. An FTE of 1.0 means that the person is equivalent to a full-time worker, while an FTE of 0.5 signals that the worker is only half-time.

Health Maintenance Organization (HMO) — A pre-paid medical group practice plan that provides a comprehensive predetermined medical care benefit. In order for an individual's health care costs to be paid, the individual must utilize services from the specified HMO network of providers. A participant's care is monitored and controlled by a selected primary care physician who is accountable for the total health services of the participant, arranges referrals and supervises other care, such as specialist services and hospitalization.

Health Reimbursement Account (HRA) — A tax free employer funded account that provides employees with medical care expense reimbursements. These accounts allow unused funds within the account to be carried forward to future years. HRAs are typically provided with high deductible medical plans.

Health Savings Account (HSA) — A pre-tax account that is funded by employees and/or employers to cover employees' out-of-pocket expenses. These accounts require an employee to be enrolled in a qualified high deductible plan. Unused funds in the HSA may be carried forward to future years.

Levy Lid — A statutory limit on the local levy, expressed as a percentage, for a school district. The levy lid effectively caps the amount of revenue a local district can raise to supplement State and federal funds.

Managed Care — Control of utilization, costs, quality and claims, using a variety of cost containment methods, including pre-certification and case management. The primary goal is to deliver cost-effective health care without sacrificing quality or access.

Maximum Benefit — The maximum amount that a health care plan will pay on behalf of a covered participant during that individual's lifetime.

OEBB — Oregon Educators Benefit Board is the governing body created by the Oregon State Legislature to administer and run a separate health purchasing system for Oregon's public school employees.

OFM — Office of Financial Management.

OIC — Office of Insurance Commissioner.

OSPI — Office of the Superintendent of Public Instruction.

Out-of-Pocket Limit — The maximum amount of out-of-pocket health care expenses that a participant is responsible for during a plan year. Every dollar spent on health care after this amount is generally reimbursed in full.

PEBB — Public Employees' Benefits Board.

PEBB Program — Public Employees' Benefits Board program.

Point-of-Service Plan (POS) — A type of managed care system that combines features of indemnity plans and HMOs and uses in-network and out-of-network features. A gatekeeper is used to direct an individual to medical care within the network. The covered participant also has the option to received care from any out-of-network provider. If care is received out-of-network, the participant will pay higher co-payments and/or deductibles.

PPACA — Patient Protection and Affordable Care Act.

Preferred Provider Organization (PPO) — A group of hospitals and physicians that contract on a fee- for-services basis with employers, insurance companies and other third party administrators, to provide comprehensive medical service. Providers exchange discounted services for increased volume. Participants' out-of-pocket costs are usually lower than under a traditional fee-for-service or indemnity plan. If the network-based health plan has gatekeeper/primary physician requirements, it is not a PPO plan, but a Point of Service (POS) plan.

Provider Network — Health care providers that have a contractual relationship with a health plan to provide care to the plan's enrollees. Network contracts define the payments the health plan will make to the providers for services rendered to enrollees. They also typically include provisions designed to ensure the quality and cost-effectiveness of care.

RCW — Revised Code of Washington.

SAO — State Auditor's Office (of Washington State).

Self-Administered Plan — Refers to a benefit plan in which the company assumes responsibility for full administration of the plan, including claims administration.

Self-Funded Plan — A benefit plan funding method in which the employer carries the risk for any claims. The employer may contract with a third party administrator to pay claims in its behalf, or may develop its own department to administer the program.

Stop-loss provision — A provision in a self-funded plan that is designed to limit an employer's risk of losses to a specific amount. If claim costs (for a month or year or per claim) exceed a predetermined level, an insurance carrier will cover the excess amount.

TPA – Third Party Administrator — In a health benefit plan, the person or organization with responsibility for plan administration, including claims payment.

Transparency — Includes detailed reporting of health benefits funding by revenue sources, as well as detailed reporting of health benefits costs by expenditure category. It relates to health purchaser benefits management as well as consumer and provider engagement.

Voluntary Employees' Beneficiary Association (VEBA) — A tax-exempt trust established to fund employee welfare benefits other than pensions. Also known as 501(c)(9) trusts, after the section of the Internal Revenue Code authorizing their tax exemption.

WAC — Washington Administrative Code.

WEA — Washington Education Association.

WSIPC — Washington School Information Processing Cooperative.